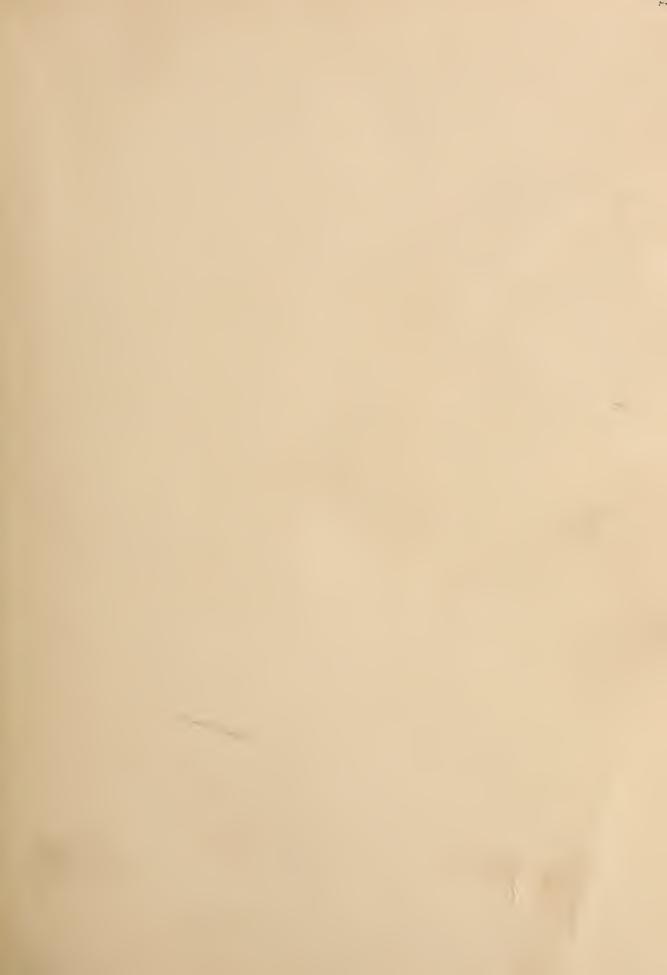


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THE JOURNAL

OF THE-

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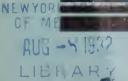
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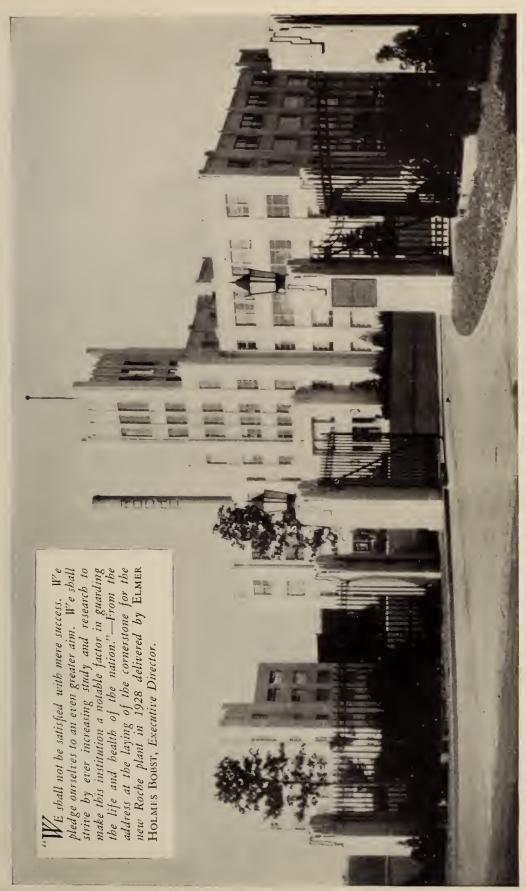
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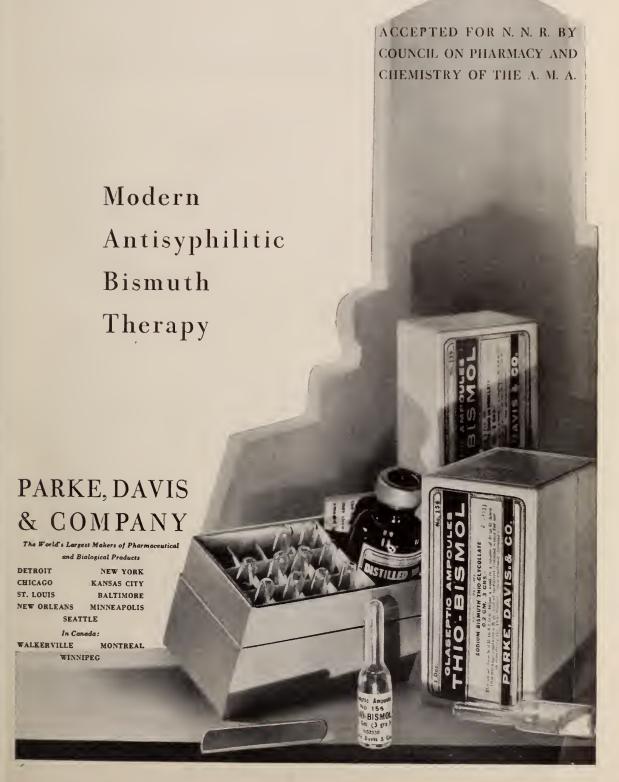
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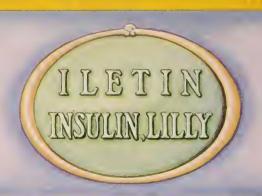
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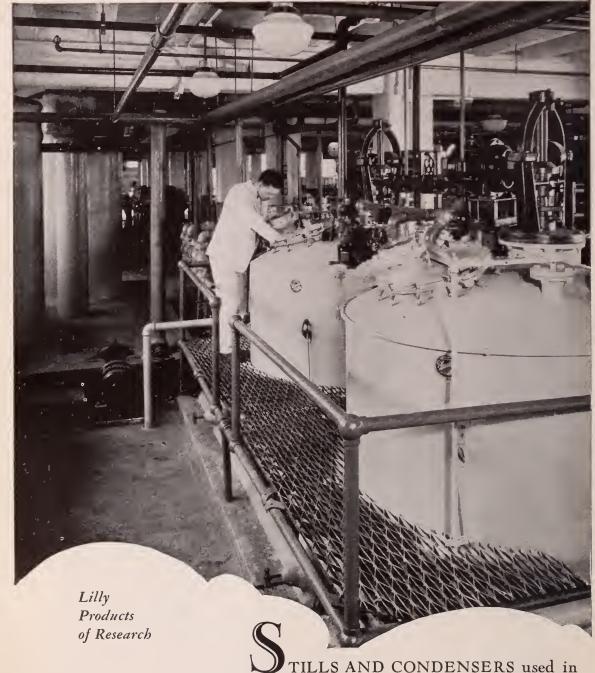
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Volume XVIII

Jacksonville, Florida, July, 1931

Number 1

TREATMENT OF FRACTURES OF THE NECK OF THE FEMUR*

Fred H. Albee, M.D., Sc.D., LL.D., F.A.C.S., New York City.

When president of the American Orthopedic Association (1929) I appointed a committee to study the results of the treatment of fractures of the neck of the femur. This study, continued for two years, has reflected so unfavorably upon the treatment of fresh fractures of the neck of the femur by the common methods that it certainly should lead even the most optimistic to analyze the whole situation and if possible, to determine the reason why such unfavorable percentages have been secured.

In making this analysis one cannot but arrive at the following conclusions: that fracture of the central portion of the neck of the femur is first most unfavorable to union because of its location completely within a joint, and so situated that a solution of continuity through it cuts off the proximal fragment from a large percentage of its blood supply from the trochanteric region. If by chance the ligamentum teres should have suffered avulsion or tear, the blood supply would then be completely shut off. It is impossible to speak in definite terms as to the relative amount of blood supply to the head and proximal portion of neck of the femur, coming from these two sources, but certainly it is safe to say that considerably more than 50 per cent comes from the trochanter region of the femur. In that callus formation has been proved repeatedly by my own animal experimental work and that of others to be in direct relationship with the amount of blood brought to the part, the importance of this consideration is evident.

From an anatomical standpoint, this fracture is unfavorable because being at the neck of the main portion of a ball and socket joint, the diameter is less than that of any other portion of the femur. Therefore because of this small cross-section area the condition is most unfavorable, for union of bone is always in direct relation to the cross section of the bone at the point of frac-

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931. ture. The larger the cross section of the bone through which the fracture occurs, the more readily it unites.

From a mechanical standpoint this fracture is unfavorable because of the fact that the proximal fragment is practically a sphere in a slippery joint cavity and very likely to move at the slightest muscle spasm. Further, the fracture being in a joint, the fracture space is immediately filled by synovial fluid which is inhibitory to callus formation. Lastly, as it is completely in a joint there is no periosteum with its osteogenetic influence nor is there blood supply coming to the point of fracture from the periphery.

In view of these physio-biological obstacles to the union of such a fracture it is apparent that the treatment should be directed if possible to overcoming them. Thus far, treatment has been directed entirely to the mechanical immobilization of the fragments, and consequently from analysis of the above statements is inadequate, as a biological and physiological influence must be brought to bear. This can apparently be accomplished in only one way; and that is by autogenous bone graft so put in that it not only mechanically immobilizes the fragments, but it further furnishes an osteogenetic callus forming influence, and also serves as a vascular conducting scaffold, conducting blood from the vascular trochanteric region to the anemic capital fragment. This function of the early vascularization of the bone graft cannot be too much emphasized.

From the above it would appear that if we are to expect a reasonable percentage of good results in fractures of the central portion of the neck of the femur, we must as a primary treatment in selected cases apply the bone-graft peg.

In the University of Amsterdam clinic when visiting that city a few years ago I learned that practically ever since I first recommended the tibial bone graft peg, they had used it in that clinic as the sole treatment for all cases of fracture of the central portion of the neck of the femur, and their results had been remarkably favorable.

I would, then, recommend the bone-graft peg for selected cases of fresh fracture and for all cases of ununited fracture of the neck of the femur at any portion of the neck, where the capital fragment is of sufficient length to favorably receive the bone-graft peg. I reserve the reconstruction or partial arthroplastic procedure which I am about to describe for those cases of long standing in which there has been so much erosion because of lack of blood supply and ill nourishment of the capital fragment, and the eroding effect of ill-advised locomotion.

AUTHOR'S BONE-GRAFT PEG OPERATION

I first described this operation in 1913 in Murphy's Clinics. First the joint is exposed by an anterior incision straight downward from the anterior superior spine; a second is made over the great trochanter for the purpose of inserting the bone-graft peg. The neck of the femur is inspected through the anterior incision. Eversion of the foot and limb causes the femoral fragments to separate anteriorly and the ends of both are then thoroughly freshened with osteotome and mallet. The foot is then restored to the antero-posterior axis and sufficient abduction (about 30 degrees) and traction applied, by means of the table, to bring the freshened fragment ends into close apposition.

Attention is next turned to the short incision over the trochanter which has been carried down to the fascia covering the vastus externus. These structures are now both split longitudinally so as to expose the lateral surface of the great trochanter. The point of application of the drill lies 1/2 inch below the bony ridge to which the fascia overlying the vastus externus is attached. Since the direction of the drill must follow the central line of the neck, due consideration must be given to the angulation of the neck to both the axis of the femur and the vertical intertrochanteric plane. In the average adult, the neck makes an angle of 130 degrees with the femur, and 12 degrees with the vertical intertrochanteric plane, when the foot is in the anteroposterior plane.

With the motor drill held in the direction thus indicated, a hole ½ inch in diameter is drilled through from the lateral aspect of the great trochanter to the broken end of the distal fragment. This point is determined by instrumental palpation of the head of the drill between the opposed fragments. The reading on the drill indicates the length of penetration through the distal fragment. With the drill head against the freshened end of the capital fragment, it is now carried into this fragment until the reading shows sufficient penetration. The degree of penetration is usually 7 or 8 centimeters (2½ inches) and is deter-



Fig. 1. Pre-operative X-ray of a carpenter who had fallen twenty feet from scaffolding. Leg put up in Hodges' splint for one month. Seen by author four months after accident, walking with crutches. Bone-graft peg operation October, 1922. End-result May, 1927: Patient doing regular carpenter's work, climbing ladders and scaffolding. Function normal. No lameness, no pain.



Fig. 2. Same case as Fig. 1. Post-operative X-ray, nine months after operation.



Fig. 3. Same case as Figs. 1 and 2. Post-operative X-ray, six years after operation.



Fig. 4. Pre-operative X-ray, showing the inefficacy of inserting foreign bodies, such as metal nails. Owing to the damage done by the nails, it was necessary to do a reconstruction operation, following which firm union and good motion were secured.

mined by a study of the roentgenogram. The drill is left *in situ* while a graft is taken from the crest of the tibia of the same side.

The tibia is exposed by a generous incision over its lower third. This lower portion is preferred on account of the greater thickness and strength of the cortex. A portion is chosen where the crest is straight and regular, and the muscle and soft tissues dissected away. With my motor saw, a longitudinal cut is made on each side of the crest at a suitable angle with each other and an interval sufficient to provide a peg 1/2 inch in diameter after shaping. Two transverse saw euts are now made at an interval equal to the reading on the drill, and the segment loosened by means of an osteotome and gentle blows of a mallet. The selected end of this segment is seized by two Ochsner clamps. The other end is inserted in the pencil sharpener cutter attached to the dowel-shaper, by means of which the end is shaped to a blunt conical point favorable not only for subsequent engagement in the dowel tool, but for reception in the drill hole already prepared in the femoral fragments. The pencil sharpener attachment is now replaced by the dowel tool and the peg run through it. During both these shaping processes, a drip of normal saline is arranged to fall constantly on the tool not only to hasten its cutting, but to relieve any possibility of undue heat. The saline solution also prevents dehydration of the graft by exposure to the air. Moreover, in the industries either oil or saline solutions are used in the cutting of hard substances, for the purpose of clearing debris from the path of the cutting instrument, as well as for increasing the speed of cutting and for diminishing friction.

The peg is now inserted into the drill hole in the trochanter (after removal of the drill) and driven home with the bone drift and mallet. With the end of the handle of a wooden mallet against the great trochanter, close to the peg graft and by means of blows of the palm of the hand or a sand-bag against the head of the mallet, I insure close approximation of the fragments.

The deep fascia is closed by interrupted sutures of No. 1 chromic catgut and the skin with a continuous suture of No. 0 plain catgut. The limb is put up in a posture of slight abduction, in a double plaster-of-Paris spica extending to the base of the toes on the affected side and to the knee on the sound side. Pre- and post-operative roentgenograms are shown in figures 1, 2 and 3.

Let us examine in detail some of the points in this technic. I have mentioned the necessity for

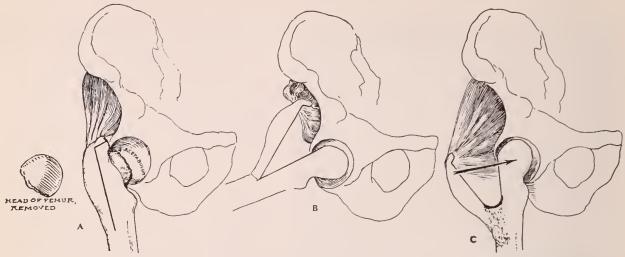


Fig. 5. Schematic drawing of author's reconstruction operation with removal of femoral head; dotted line indicates bone section of upper end of femur by broad osteotome.

Fig. 6. Displacement of upper end of bone muscle lever outward by abduction of hip which automatically thrusts the new femoral head into the acetabulum at the same time holding the bone muscle lever in oblique relation to the shaft. The angle is then filled with cancellous bone material from greater trochanter.

Fig. 7. When the leg comes to the midline or beyond, dislocation is prevented by the outward excursion of the proximal end of the lever and the resultant tension not only on the trochanteric muscles, but on the soft parts surrounding them. This causes the newly formed head to be jammed firmly into the acetabulum, as shown in Figure 7.

consideration of the relation of the neck of the femur to the planes of the body. It was stated at a meeting of some of the world's most eminent orthopedic surgeons that the operation was "too difficult for any but the special few." I would be in agreement with that statement if it were impossible for all but the few to visualize the course of the femoral neck and to direct their operative procedure in accordance with the clear anatomical demands. The results which one eminent surgeon showed in roentgenograms of bone pegs that missed the capital fragment entirely or went clear through into the pelvis, would make one tremble for the future of surgery if it were to forsake so completely its foundation on the precision of anatomy.

Success in surgery depends more on anticipation of difficulties than on skill in overcoming the unexpected. By means of the graduated drill and palpation between the fragments, one can determine the point to which the drill hole ought to be carried. No phenomenal skill is required; all that is demanded is preparation, prevision, and precision.

Neither in fresh fractures nor in non-union is the use of nails justifiable. (Fig. 4). If, after skilful and correct application of the Whitman abduction method in fresh fractures, the fragments do not unite, the problem goes beyond mere mechanics and becomes a biological as well as physiological one. Nails are foreign bodies and have no biological or physiological properties, except destruction, as those of us who have been removing nails for years and observing their destructive influence can emphatically attest.

Accuracy of fit of the autogenous bone graft peg is another essential. This can be accomplished only by the use of electrically driven automatic machinery which brings about a fit commensurate with that of a glass stopper in a bottle. The insertion of the graft should not produce compression by too tight or inaccurate a fit, nor should there be a dead space, filled with air, blood clot, or tissue debris, between the surface of the graft and the host bone tissues. In other words there should be the closest coaptation of the haversian canals of the host and graft tissues so that early and complete vascular canalization of the graft will take place. Obviously a graft of irregular cross section will not do. The square peg in a round hole is a misfit here as in every other human endeavor. The early and complete vascularization which will occur only in an accurately fitted autogenous peg graft is not only essential to survival of the graft, but serves to carry blood and callus forming material to the anemic capital fragment and to the point of fracture.

TECHNIC OF AUTHOR'S RECONSTRUCTION OPERATION

This operation, as I have already said, is reserved for cases of long standing non-union in which there has been much erosion because of

lack of blood supply and ill nourishment of the capital fragment, and the eroding effect of ill-advised locomotion.

The approach is that devised by Smith-Petersen, and is very similar to the Sprengel approach. The skin incision consists of two parts: (1) from the anterior superior spine directly downward, and (2) from this point over the anterior superior spine directly backward along the crest of the ilium for a distance of 3 or 4 inches. With a scalpel the fascia lata is severed parallel with the crest of the ilium and sufficiently below it to leave a fascial flap to receive sutures in the approximation of the severed fascia lata at the close of the operation.

Then, with the wide osteotome used for splitting the spinous processes in my operation for Pott's disease, the muscles are stripped down from the side of the ilium by subperiosteal separation, and are separated from one another directly downward from the anterior superior spine. The capsule of the hip joint is completely exposed. The joint is entered by a T-incision with the stem running directly downward along the neck of the femur. The head of the T is made about three-fourths of an inch from the rim of the acetabulum, for the purpose of furnishing a cuff of capsule to act as a lining of the outer portion of the joint, and for the neck to rest against when the head has been reconstructed.

Care should be taken to make the incision into the capsule sufficiently spacious so that the difficulty of getting the head out of the acetabulum will be minimized. The ligamentum teres is then severed by means of a half-inch osteotome thrust deep into the joint, and any adhesions of the capsule to the periphery of the head are carefully separated with a scalpel.

The limb is then strongly everted by adjusting the Albee fracture table, so as to make room for the delivery of the head. With two long half-inch chisels or osteotomes, the head is pried out of the acetabulum, with a motion much like that used in eating with chopsticks; one osteotome is thrust into the inner and one into the outer substance of the head, and the two are used as levers against the soft parts to pry the head out of place.

As soon as the head is delivered, the patient's limb and foot should be inverted by adjustment of the table, so that the foot points directly upward. Then, with the scalpel, the soft parts are severed in a straight line down on the anterior surface of the great trochanter, to admit the wide

(1½ inch) osteotome that is to split off the lever as indicated in Figure 5. With this and a one-half inch osteotome, a lever measuring about 4 inches from the tip of the trochanter, including about one-sixth of the diameter of the shaft of the femur, but only a shell of bone at the tip of the trochanter, is separated and pried outward, producing a greenstick fracture at the lower end. The half-inch osteotome is used to remove the shell from the superior tip of the trochanter with the muscle insertions.

The second part of the bone incision at right angles with the first is made with the $1\frac{1}{2}$ inch osteotome from above downward, care being taken not to separate the muscles and soft parts from the bone while doing it.

The last step is to fracture the bone muscle lever outward at its extreme lower end by using the wide ostcotome before its removal as a lever (Fig. 6). Fragments of cancellous bone, removed from the cut surface of the trochanter and shaft by means of a curette, are placed in the angle of the gap thus formed. (Fig. 6). The stump of the neck is then rounded so as to cause minimal irritation of the acetabulum.

The assistant is directed to adjust the table so that the limb is brought to the limit of physiological abduction at the hip, and at the same time the upper end of the femur is lifted forward and guided into the acetabulum. Thus the bone lever is automatically held by the posture in the position shown in Fig. 6.

The bone-muscle lever is pulled anteriorly and held with medium kangaroo sutures in surrounding attached soft tissues. The wound is now ready for closure. All dead spaces are overcome by means of continuous suture of No. 1 chromic catgut. The skin is closed by continuous suture of No. 0 plain catgut. The line of incision and the suture holes are puddled with tincture of iodine, 3.5 per cent.

The leg is then put up in a long spica, extending from the tips of the toes to well above the costal margin, with the abducted position undisturbed. The plaster is so molded as to hold the upper end of the femur anteriorly and is kept on for a period of seven weeks. The leg is then allowed gradually to resume the normal position. The patient is persuaded to begin walking with crutches immediately, and daily massage and manipulation at hip and knee are at once instituted.

I first performed this operation in 1915 and

published the technique in 1919, several years before Whitman described his operation of similar nature. I still feel that it offers the best method of dealing with ununited fracture of the neck whenever erosion has produced such extensive loss of tissue of the neck that the bone-graft peg cannot be applied.

The choice of operation is determined by the condition of the fragments; and this depends on the previous treatment of the case as well as on the co-operation of the patient in that treatment. In some border line cases the choice of operation cannot be determined until the head and neck of the femur have been exposed.

A careful study in 1929 of the end-results in the author's series of one hundred sixteen cases treated by autogenous bone-graft peg and one hundred and twelve treated by his reconstruction operation showed the late end-results to be excellent in 90 per cent of the bone-graft peg, and 78 of the reconstruction. The mortality has been 2 per cent for the reconstruction cases; no death has occurred in the bone-peg series. These statistics are most gratifying when we consider that ununited fracture of the neck of the femur is one of the most disabling of all traumatic lesions, and one of the most difficult problems in surgery because of the anatomico-physio-biological conditions, and because of the erosion that has so often taken place before the surgeon is consulted. Function is usually good within six months after operation.

OTIC MOLD INFECTION* L. C. Ingram, M.D., Orlando.

During my sixteen years of practice in Florida I have observed an increasing number of ear infections which were the direct result of some fungi. Otomycosis is generally considered an infrequent and an unimportant ear disease. My observation, however, leads me to believe that the infection is quite extensive, at least, in certain localities. It is most extensive in the tropics and semi-tropics and along the sea coast. In this locality the moist, warm climate is conducive to the spread and growth of all fungi. Simple mold infection of the external ear canal may produce no symptom or possibly only moderate itching until water is introduced into the canal, when an abundant growth of mold, or additional infection

with pus germs, may institute alarming symptoms. Contacts which I formed through presenting a similar paper three years ago have strengthened my view as to the frequency of the infection in this locality and prompted the preparation of this paper.

HISTORY OF OTOMYCOSIS

Mayer is reported to be the first to observe and report a case of aspergillas infection in the external ear which he did in a paper in 1844. Pacini made a similar report in 1851. In 1867 Schwartze reported a case and his article attracted general attention and discussion by the medical profession in all lands. Schwartze stated in one sentence: "It appears to be very probable that this vegetable parasite is more frequently a cause of obstinate, frequently relapsing and chronic inflammation of the ear, than is generally supposed." The first text-book on diseases of the ear to include a discussion of this disease was St. John Roosa in 1873 in the text, "Practical Treaties on Diseases of the Ear." The representative text-books of today have only the briefest discussion of otomycosis. Castellani and Chalmers in their text, "The Manual of Tropical Medicine," say that otomycosis is a common disease in the tropics. A correspondence with physicians in other countries, as well as the United States, however, has given me the best picture of the distribution of the disease. The heaviest infestation is located in hot climates and near the sea coast.

In recent years considerable information has been added to our literature on parasitic fungi. Not only has more been learned of methods of identification, but studies have extended materially our knowledge of the diseases and the organs affected. In the literature on parasitic fungi there are at least ten different species reported in these ear infections. By far the greater number are of the family aspergillaceæ. The most common species is aspergillus funigatus. A very troublesome disease of anterior coana of the nose, one of the eyelids and others of the tonsils and pharynx are all described under fungi infection. There is at least one large text-book published devoted entirely to a study and identification of the aspergillus.

SYMPTOMATOLOGY AND DIAGNOSIS

As stated above, the patient may have a mold infection in the ear and have no symptom until water or oil has been introduced, when he may have intense itching, or experience pain in the ear or the side of the head. This usually will cause

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

him to consult a physician for relief. He often complains of the itching being worst at night. Not infrequently he has introduced a match, hair pin or other article into the canal and in scratching brought about an additional infection of pus germs in the form of acute diffuse external otitis, or the circumscribed form or furuncle. Either situation frequently complicates the mold infection and brings to us for treatment many patients suffering intense agony. Sometimes we may have irrigated an ear to remove impacted cerumen and shortly after the patient may return with an acute diffuse external otitis or infection in middle ear, to show us what a good job has been done. Many cases of impacted cerumen have a mycotic infection. There may be swelling of the canal, impairment of hearing and a dull pain. The pain may be violent, shooting or radiating back of ear and cause the patient to feel certain that he has beginning an infection in the middle ear, or he may be alarmed over a mastoid infection. Some cases have been actually diagnosed surgical mastoid. Such cases can be cleared up by a careful study of their history, a recognition of the diffuse swelling of the canal, the pain in the front of the ear, and on manipulating the ear and an absence of middle ear infection and drainage. Pain in some form seems to be the most constant symptom. Not infrequently tonsils have been removed or some teeth extracted with the promise that it would relieve the pain. There is considerable odor with some of these infections and sometimes they are diagnosed cholesteatoma.

It is my belief that in our locality many of these fungi find conditions abundantly favorable for growth in their saprophytic form. Many of the spore forms find entrance to the external ear canal. They are protected here and if by chance water or oil is added to the ear multiplication takes place rapidly. If the epidermis is thin, or there is a sensitive patient the growth penetrates to the true skin and there is soon a reaction and flow of serum to help the growth. At this stage there is some absorption and the reaction is similar, if not exactly alergic. Some patients are much more susceptible to this toxin than others, and in these the infection is of the moist or eczematous type. Others that are less susceptible, but have the growth started, remain of the dry crusty form having no reaction of the skin to supply the serum and moisture.

If the patients are not treated, or not properly treated, the trouble usually will last for years with the acute stage introduced in early summer or after bathing in the lakes. Patients treated by the most approved method known will not all remain well and must be told this and advised to use some medicine in the ears, and to call at the office, say once a month, for at least three months.

We must make a complete and careful examination of each case, study its history to see if it has had previous attacks and note if there was a period of itching in the ears. Almost every case will report itching ears at some time before this attack. Some may have had a mushy clot removed from their ears at another time. A careful inspection must be made of the canal before it is disturbed. After a few cases have been seen the picture will be strikingly similar in the majority of cases. One will be a lead color or grav clot that can be removed with the small ear forcep. Another will be a brownish soft mass similar to a collection of cerumen. My experience is that this form, though not so frequent, is the hardest to cure. In the past year I have used a remedy cresatin, that seems more successful. Sometimes there is a brown or gray film almost like velvet that lines the canal back to the drum. In others only the drum and canal wall near it is covered. After a good view of the canal some of the mold can be removed for observation under the microscope. A new method for preparing the specimen was recently reported by Dr. Theodore Cornbleet, of Chicago, in December 6, 1929, A. M. A. Journal. Sufficient water is added to sodium sulphide crystals for solution, then an equal amount of 95 per cent alcohol is added. Distilled water is then added until the precipitate re-dissolves. After the specimen is covered with the slip the reagent is added and enters around the side. It clears shortly and can be examined at once for mycelia. However, unless we have had considerable training and experience we cannot go far in differentiation of the varieties of fungi.

It is well to remove the mold or clot with an applicator and cotton wherever we can, for in doing this we can observe the nature of the growth and the amount of injury done to canal wall or drum. Sometimes the drum is perforated by this mold, and in this way it has extended to the middle ear. I use one per cent silver nitrate on my applicator, for the moist cotton does better than the dry and silver is of benefit in destroying the fungi. Usually the mold will roll up in little cylinders like rubbing moist blotting paper.

The question has been raised at times as to

whether the eczema, furuncle or other pus infections were secondary to a mold infection that injured the canal wall, or whether the mold was planted upon eczema and pus infection. A careful study of many of my case histories has convinced me that the mold infection was first.

Instead of giving a group of case histories, I am presenting a report on one hundred cases treated by me during 1930, not all new cases for several had been treated during previous summers. The following information was secured: ninetysix were white and four colored, forty-eight male and fifty-two female. Eighty-five had lived in Florida three years or more, eight had resided here one to three years and seven were here as tourists from the north. Seventy-five per cent of the cases were seen during the five warm months, May, June, July, August and September. Fiftyfive had ages recorded and forty-five no age recorded. Of the fifty-five, two were under one year, voungest cases I remember of seeing. From one to ten years there were eight cases; eleven to twenty years, nine cases; twenty-one to thirty years, seventeen cases; thirty-one to fifty years, fifteen cases; fifty-one to seventy-five years, four cases.

A study of stage and condition of the one hundred cases revealed the following: the primary stage, itching or pain without complications or swelling, having a gray or lead colored film or clot, fifteen cases; primary same with soft brown putty mass, ten cases; the same with cerumen plug and mold, seven cases; of the more severe with swollen canals, dermatitis or eczema, thirty-five cases; the same with pus infection, furuncles or other reaction, twenty-seven cases. There were three cases, two out of state and one in state, that had had radical mastoid operations. There were three that had polyp from middle ear.

From this study we obtain the following information: by far the largest number of cases occur during the summer and in people who have lived here the year around for five or more years.

I see as many tourists as home folk during the winter months and find four times as many ear infections among home folk. Any age may have the trouble but far the greater number are from thirty to fifty. There is but little difference in sex, only four more female than male.

TREATMENT

A number of remedies have been offered and used in the treatment of this disease, one at least,

alcohol or alcohol and salicylic acid, has always been popular. Although alcohol and salicylic acid have been used so universally I am of the opinion that we have better remedies now, at least more pleasant for the patient.

In a study of the literature and from correspondence I found the following remedies most favored: alcohol eighty-five per cent; alcohol and salicylic acid, silver nitrate one per cent; analin dyes, preferably gentian violet, S. T. 37, ultra-violet lamp, mercurochrome two per cent; thymol three per cent in alcohol, cresatin, potassium iodide in ten grain doses by mouth in conjunction with local treatment.

In deciding on the remedy to be used we must be influenced by the stage of the disease and the complications, if there are any. I can explain this best if I present my plan of treatment. In the milder cases the ear canal is cleansed first with applicators soaked in one per cent silver nitrate. Dry them and paint with mercurochrome two per cent. I give a prescription of mercurochrome two per cent to be dropped in the ears once a day and then dried out. If there is a dry, scaly canal with a lot of itching, or if the canal is filled with a brown putty substance I clean it out and paint the canal with the mercurochrome, then give a prescription of cresatin, five drops to be put in ears once a day and then dried out. In either case I see the patient in three days and again clean out the ear canals. Usually the film will roll up and remove easily at this time. Such treatment is continued until the canal wall is clean and the skin normal, except that where cresatin was used I change cresatin to mercurochrome at the end of a week.

Where pus germs have entered to complicate the case, if diffuse, I use ice, if furuncle and ready to be opened it is drained. With all of these I use a weak alcohol boric solution in the ear and then use graduate doses of vaccine. My favorite is Van-Cotts combined, beginning with four drops and repeated in two days, increasing the dose by two drops. Eighty per cent of the cases recover in from six to ten days under this treatment.

SUMMARY

There are many unrecognized fungi-infected external ear cases in the warmer parts of our country, especially near the sea coast. The little interest given the disease may be due to the fact that most information or reports were prepared through a study of the disease in a colder or less susceptible climate.

The diagnosis with most cases will be easy from a study of the history of the cases and a familiarity with the picture to be seen on inspecting the ear canal.

The treatment here presented is uniformly successful in clearing up the attack and, if the patient will cooperate in the final clean-up treatment, only a small number of cases will recur.

DISCUSSION

Dr. II. Marshall Taylor, Jacksonville:

The subject of otomycosis, which Dr. Ingram has brought to us, is of considerable interest to physicians residing in Florida. As he has stated, it is primarily a disease of the tropics or semi-tropics and little has been written about it by our students. In four years of hospital and clinical experience in New York and Europe, I did not see one case of otomycosis. In Florida I see many scores of it annually.

The aspergillus seems to be dependent upon moisture for its growth, and for this reason it is seen more frequently in the summer months. The spores may exist through the winter without symptoms, but with the advent of summer and the swimming season and the increased amount of perspiration, the growth of the mold is acclerated. When the hyphae of this mold penetrate the pigmented layer, severe papin is often described and a tinnitus is often developed.

We have three principal types of this fungus: aspergillus niger, or black type, aspergillus flavus, or yellow type, and aspergillus fumigatus, or gravish black type.

Dr. Ingram reports that he has observed more frequently the aspergillus fumigatus, or grayish black type. In Jacksonville I believe I see the yellow form, or aspergillus flavus, equally as frequently. Fortunately, this condition responds very readily to treatment, and is completely relieved if treatment is continued over a period of time.

Dr. Ingram reports the use of cresatin in his treatment. I know nothing of this preparation, other than that it is a non-official preparation put up by Merck. However, since Dr. Ingram has had success with it, I am sure that it is good to use.

In my hands the following treatment has given me every desired result: a one per cent solution of salicyclic acid in seventy per cent alcohol is instilled into the ear every four hours. The head is tilted to the opposite direction; that is, if the aspergillus or mold is in the right ear I turn the head over to the left and fill the ear canal with this solution. It is not sufficient only to fill the ear with the solution, but to allow it to remain from two to five minutes. For the first two or three days, the patient may complain for a moment, but only for a moment. After you use salicylic acid solution and alcohol for a few days a crystal-like deposit forms in the canal. The best method to get rid of it and also evacuate the canal after treatment, is to wash it out with a twenty per cent tincture of hydrastis. I don't think anything else gives the patient as much relief or the physician as much satisfaction.

I am glad that Dr. Ingram has brought this subject to us and I hope he will continue his investigations along this line.

Dr. M. A. Lischkoff, Pensacola:

I have enjoyed this paper very much, and, like the two speakers, have observed very little of this condition away from Florida, but here in Florida we see a lot of it.

The molds are unable to proliferate unless conditions in the canal are such as to supply a moist or macerated epithelium. Trauma, such as skin maceration from excessive bathing, or any other exposure of the canal to long soaking in water, represent most of the cases we see.

It is probable that otomycosis is always secondary to some infection which provides the conditions under which it thrives. Once invasion takes place, the spores proliferate rapidly, and though the visible products may be easily removed, a permanent evacuation is extremely difficult and rarely accomplished.

The most common fungi encountered in this state are aspergillus funnigatus common to cereals, hay, and straw, and Penicillium, from decomposing bread, cheese and food stuffs. However, as Dr. Taylor says, we frequently see the aspergillus flavus.

A localized infection, common to the canal seen throughout the tropics, is known as Calcutta, Java or Hong Kong ear, according to the geographical location; J. M. Forsyth called it "tropical ear." He divided it into two groups, otomycotic and bacterial. In the first group of fifteen cases, fourteen were aspergillus and one a yeast saccharomyces.

Dr. L. L. Whiddon, Ft. Pierce:

I think we all have a good bit to do with this mycosis on the coast. I saw a report the other day, on this subject, and just from that I am discussing this paper.

There was a doctor from Albany, New York, reporting on this mycotic condition in an article, and he called attention to the fact that sodium thiosulphate five per cent solution, was very efficacious. After reading that paper, I began using it, and I want to tell you the result is almost marvelous. For that reason I commend to you sodium thiosulphate for trial.

MANUAL ROTATION OF THE ENTIRE FETUS IN THE OCCIPITO-POSTERIOR POSITIONS AS SUBSTITUTE FOR FORCEPS ROTATION* M. C. Wilson, M.D., Miami.

There is nothing new or original in this article, for manual rotation has been in use by our best teachers for many years. The purpose of this article is to stress its advantages in the management of certain cases of occipito-posterior positions, where interference is indicated; to suggest its use to the general practitioner and obstetrician who dreads the task of applying forceps on occipito-posterior cases; and to encourage the use of this maneuver earlier in these slow cases so as to materially shorten the duration of labor in those cases ordinarily left for the maternal forces to correct.

Norris W. Vaux, in a splendid article in the Journal of Obstetrics and Gynecology, December, 1930, reports that in one thousand, two hundred and sixty-eight deliveries in the Philadelphia Lying-in Hospital, he found 16.7% to be occipito-posterior positions. Various authors report the occurrence in 2 to 10% of cases. LaVake² states that of 100 cases of occipito-posterior positions diagnosed early in labor, 80% will rotate and deliver as occipito-anterior unaided or assisted by low forceps; that 5% will cause serious difficulty in deep transverse or sacral arrest and require forceps delivery.

A definite and certain diagnosis of this occipitoposterior position should be made as early in the first stage as possible and this is not by any means easy in some cases. By abdominal examination alone, we are often able to make a diagnosis or at least to strongly suspect this position. The breech is felt at the fundus and on tracing the trunk downward, instead of feeling the firm broad back anteriorly, we find a hollow between the breech at the fundus and the head at the brim. In this hollow are easily felt the limbs more to the front than the firm smooth back which can be felt along one flank. By Pawlik's grip, the head is found fixed at the brim. Owing to the usual imperfect flexion of the head in these cases, the occiput and the forehead are felt with equal ease and on about the same plane. The fetal heart is usually heard best in the flank but not as distinctly as in the anterior positions. At times, the heart is heard higher up and more to the midline if the fetus lies on its back. If the mother's abdominal wall is fat, thick, or muscular, or the uterus tense, it may be impossible to arrive at a definite diagnosis of the position by abdominal examination. Rectal examination should disclose the fact of occipitoposterior position if the cervix is thin and partially dilated. The head is usually still higher up and the fontanelles difficult to outline. When we suspect this condition, or definitely diagnose it early, we should take measures to carefully preserve the bag of waters and to conserve the strength and vital forces of our patient by encouraging rest, abundant fluids and frequent light lunches. She should not be allowed to pull on sheets nor attendants' hands as it is useless and exhausting and tends to cause early rupture of the bag of waters.

After the cervix has dilated sufficiently to outline the fontanelles, the diagnosis is easier. The posterior fontanelle is outlined and by tracing the sagittal suture as it leads forward toward the symphysis, or as often is the case, tranversely, we encounter, nearer the pubis than the sacrum, the large anterior fontanelle pointing to the side on which the limbs were felt anteriorly. The forehead is pressed firmly against the pubic bones while the occiput is found not so firmly against the sacrum and we can easily push the fingers between occiput and sacrum leading us to think that there is ample room and we wonder why more advancement is not made. X-ray with the use of the perforated lead plate is advised early before rupture of membranes, if possible, to confirm the diagnosis and to determine more clearly any abnormalities of fetus and the relative size of the head and pelvis, as contracted pelvis are frequently found in these cases.

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

Careful internal and external measurements should likewise be made and when the diameters are found to be relatively small, one should religiously avoid frequent examinations either vaginal or rectal so that abdominal delivery may be resorted to more safely if the test of labor shows it clearly indicated. At times, due to overlapping of the fontanelles or to the caput or to inability to reach the parts either by rectum or vagina, we are unable to determine what the position is. The patient may not tolerate any pain incident to a more thorough examination and we are then justified in giving a light anesthesia in order to definitely diagnose the position by feeling for an ear. Usually, however, the character of the labor and the abdominal and rectal touch lead us to suspect very strongly that we are confronted with an occipito-posterior position long before there is any indication for interference. The pains are less effective, more irregular and less progressive in frequency and intensity. Labor is apt to be prolonged and the patient feels that she is not making progress.

Having definitely determined from various examinations that we have an occipito-posterior position to deal with, it has been my experience that a great many hours of tedious labor can be eliminated by the following procedure:

On admission to hospital, shave, give cleansing enema, scrub with green soap, dry and paint wide over vulva and thighs with mercurochrome 5% aqueous solution. Also instill into the vagina with asepto syringe one-half ounce of 5% solution of mercurochrome. If the patient is in distress from pains, morphine sulphate 1/8 to 1/6 grains with scopalamine 1/200 is given by hypodermic and repeated in two or three hours as the case may demand. Fruit juices, water and light diet should be given at frequent intervals. Special attention is given so that the bladder is kept empty, by catheter if necessary. The room should be kept darkened and free of solicitous friends and the patient encouraged to rest between pains during the first stage. Every effort is made to prevent early rupture of bag of waters as this is of great importance in saving the child from undue pressure, and helping to dilate the cervix and to make easier any turning that may be necessary by version or axial rotation. Keeping the patient in bed and warning her not to strain or pull down preserves the bag of waters. The patient should be made to lie on the side toward which back and occiput point as this assists anterior rotation. I

have not used the towel rolls suggested by some men. Dr. B. P. Watson of Sloan Maternity, now a part of Presbyterian Medical Center, strongly advocates the application of a roll made by a hand towel between the anterior shoulder and mother's anterior superior spine, held in place by abdominal binder or by adhesive plaster. He also urges this measure in changing this position two weeks before labor begins if diagnosed at that time.

If, after several hours of hard tedious labor, the patient has not been kept fairly comfortable by the injection of morphine and scopolamine and the cervix has not dilated more than three fingers, I order the Gwathmey ether oil rectal anesthesia which, in the majority of cases, will give relative comfort to the patient and her relatives, for two to five hours. This may be repeated with safety if there is still no appreciable change after three to six hours and the patient is in great distress or of a hysterical type.

As soon as the cervix will admit two or three fingers a vaginal examination, under strict aseptic precautions, is made to determine more accurately the diagnosis and to try to rotate as early as possible into an anterior position. The two fingers in the vagina flex the head well and press the occiput around out of the sacral hollow, or if in the transverse, rotate further anteriorly. find, by straddling the head with two stiffened extended fingers, one finger over each parietal bone, that I can sometimes rotate the head at the same time assisting, by counter pressure, with the other hand externally over the forehead and shoulder, forcing the buttock down so as to flex the fetal spine. The two fingers may be kept within the cervix to keep up flexion and rotation with each pain. Great care must be taken not to rupture the membranes if still intact. If this attempt at rotation does no good, we must patiently wait until the cervix will admit the whole hand. but the patient should be kept fairly comfortable by some means or other, such as may be deemed advisable.

When the cervix will admit four fingers and interference is indicated by lack of advancement of the head and it is evident that a persistent occipito-posterior exists I prepare to do the axial rotation. The patient is told that I am not going to deliver her now and that her baby will not be born when she wakes up. She is again painted and vaginal instillation of mercurochrome is done. Ether is given and the patient is draped with sterile towels or sheet and the perineum is first

well stretched and ironed out with the sterile gloved hand. Next, a careful examination is made to verify the existence of the posterior position by feeling for the ear and to determine in which diameter its posterior margin is pointing. The head is raised up enough to allow the fingers to grasp or touch a shoulder. I use my right hand in all cases and find it is not necessary to remove the hand until the rotation is completed. It is best to turn the fetal body by grasping the most accessible shoulder which is usually the posterior one. The baby should be turned completely over or rotation of 180° so that a definite anterior rotation of occiput and shoulders exists and so that it will not revert to the former position. If the complete rotation can be done by grasping the head internally and external manipulation of the shoulders, it is done. Be sure before you cease that the shoulders have been rotated as well as the head. The fetus should then be pushed well down to the point to which it had advanced, with head well flexed and pressure over fundus kept up. Care should be taken not to disturb a low placental attachment and to prevent prolapse of the cord. In some instances, if the membranes are carefully dissected away from the lower segment of the uterus the rotation can be done without rupture of the membranes though it does not matter so much if they are ruptured at this stage. I frequently do no more at this time, and being absolutely certain that I have now an occiputanterior position I allow the patient to come out of the anesthetic and give her a chance to deliver normally before using the forceps. If forceps or version is deemed best due to contracted pelvis it may be done at this time. If later on forceps are necessary it is far easier for me to apply them on an occiput-anterior than a posterior position. I believe that one avoids much trauma to the fetal and maternal tissues in doing this rotation by introducing the hand under aseptic precaution than in trying to force rotation by forceps on the head and by dragging down the larger diameter of the head, namely the occipito-frontal. axial rotation, we will bring the smaller suboccipito-bregmatic diameter to fit the outlet. viously, it is easier on the perineum to deliver as an anterior and, by using the lateral episiotomy in time, the perineum will be left in much better condition than if delivered as frank posterior position. Expensive forceps are not needed as a rule, though if there is a markedly contracted pelvis or a large baby a Kielland or an axis traction forceps may be indicated even after the correction to an occiput-anterior position. One is more encouraged to start the application on the anterior position with which we are more familiar and more certain of a successful delivery than if still confronted by the posterior complication.

All authors suggest an "attempt" at axial rotation for the correction of this position. However, I believe that if a determined effort at axial rotation, by grasping a shoulder, is made with the patient under ether that any practitioner capable of applying forceps or doing internal podalic version, can certainly turn, by this means, any occiput posterior to a definite occiput anterior without trauma to the mother or to the child. I had occasion to use this method recently in a very trying case to which I was called in consultation.

The woman, a primapara, had been in labor for thirty hours and the uterus was in a state of tetanic contraction. The baby weighed over nine pounds, was dead and in rigor mortis and just as stiff as a plaster cast. An attempt was made to deliver by high forceps but no advancement was made by reasonable force. Next, I attempted to turn the baby by the shoulders but found it would not rotate. Morphine, adrenalin and ephedrine had been given to relax the contracting Bandl's ring and only after very deep ether anesthesia was I able to rotate the fetus into an anterior position and then by applying forceps, after fitting the smallest diameter of the head to the pelvic outlet, I was enabled to deliver this very difficult case. Destruction of the fetus should have been done but suitable instruments were not available. The mother made an uneventful recovery.

CONCLUSIONS

- (1) Manual rotation of the fetus by the hand in the uterus corrects a serious occipito-posterior position into a normal anterior position.
- (2) Once corrected by turning the shoulders as well as the head, it will not revert into posterior position.
- (3) Correction of the "attitude" by the flexion of the head and the spine is an important part of this procedure which further facilitates towards making a normal outcome of the case.
- (4) It should be done earlier than is customary in the slow tedious cases. Do not wait until patient is exhausted.
- (5) It is easier done by the general practitioner than a version or a forceps rotation on the same case

- (6) There is less trauma to the cervix and perineum than a delivery as frank occipito-posterior as it adjusts the smallest diameters of the head to the pelvic outlet.
- (7) Expensive forceps are not so essential after rotation and are more dangerous in the hands of those unaccustomed to using them.
- (8) Obviously, it is not indicated in those easy cases which deliver within a reasonable time or show satisfactory progress.

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SACROILIAC STRAIN FROM THE STANDPOINT OF THE RAIL-**ROAD SURGEON*** CAROL C. WEBB, M.D., Pensacola.

Sacroiliac strain is commonly spoken of as that condition which is variously termed "subluxation," "separation," "dislocation," or "relaxation" of the sacroiliac joint. Suffice to say, it is a subcutaneous injury to the soft parts about the sacroiliac joint precipitated in a large majority of cases by direct or indirect violence or traumatism. A history of a heavy lift, awkwardly placed step, direct injury to the lower part of the back, intraabdominal tumors, straining by constipated patients at stool, difficult labors, or long-continued sneezing in hay fever are justly considered as potential forces to cause this condition.

The anatomy of this joint will be remembered as that portion of the bony frame of the body sustaining the greatest weight and made up of the articulation of the two ilia with the sacrum and it, in turn, with the fifth lumbar vertebra. joint, while quite well protected from a bony standpoint, is not so well protected from a ligamentous strength, because of the peculiar position of the vertebral column in its articulation with the sacrum. It supports the weight of the trunk and acts as a "shock-absorber" from the lower extremities, maintaining equilibrium and balance compensating for trunk or lower extremity strain. The articular surfaces are covered with hyaline cartilage and are held in place by anterior, posterior, ileo-lumbar, sacro-tuberous and sacrospinous ligaments. Having evoluted from the quadrupled to the biped, we find that the ligaments

have not made the necessary evolution and that the anterior is weak while the posterior is quite The ileo-lumbar extends horizontally and laterally from the hip of the transverse process of the fifth lumbar vertebra to the crest of the ileum on its inner lip. The sacro-tuberous is attached mesially to the posterior inferior iliac spine, to the posterior surface of the transverse tubercles and sides of the third, fourth and fifth sacral and coccygeal segments. The sacro-spinous ligament is triangular in shape with its base to the lateral margins of the sacrum and coccyx and its apex to the isshial spine. Therefore, you can see that painful backs arise because the joint is vulnerable from four directions in regard to its ligamentous attachments and from two directions in regard to its cartilage.

The symptoms develop suddenly following some kind of trauma. Pain is the first and most constant, usually on the affected side, and it may radiate upward in the lumbar region and downward along the thigh from the synchondrosis, with limitation of motion of the lumbar spine. Secondly, there is fatigue of a persistent nature with dull aches and pain in the region of this joint, when bending forward or turning the trunk, in most of the cases the discomfort remaining when walking or sitting. Tenderness over the joint is present on pressure and the muscles involved are rigid; stooping is always difficult. There may be favoritism for weight to be borne by the uninvolved side with or without tilting of the ileum on the affected side. In the severe types of recent development, labored breathing, exhaustion, nervousness, irritability, sweating and helplessness may exist.

To establish the diagnosis, a careful history must be elicited and the patient subjected to a careful examination, preferably with all clothing removed, standing, walking, lying prone and supine. Inspection will show postural favoring, limitation of motion, evident deformity, swelling and ecchymosis if such exists. Palpation will demonstrate localized tenderness, muscle rigidity. Verrall considers that pain felt over the joint on compression of the iliac crests or of the os pubis is conclusive evidence of sacroiliac lesion, and that its absence contraindicates such a diagnosis. Manipulation will always cause pain and will, by the aid of measurements, show leg shortening, if Vaginal and rectal examinations are valuable in ruling out uterine retroversion, palpation of the sciatic nerves and lower margins of

^{*}Read before the Twelfth Annual Meeting of the Florida Railway Surgeons' Assn., Orlando, May 11, 1931.

the sacroiliac joints, and carcinoma of the prostate or any gross intrapelvic lesions. Sacroiliac strain must be differentiated from sciatica, arthritis, lumbago and focal infections that influence them and always tuberculosis, syphilis and congenital abnormalities must be excluded. X-ray does not help in diagnosis of sacroiliac strain, but is valuable in ruling out such conditions as fracture, infections and neoplasms and, when negative, it is usually a good indication of the justification of the diagnosis in the presence of suggestive symptoms. Because of the old adage that "one cannot see pain," malingering of this complaint has become marked, as most laymen are cognizant of the fact that with chronic sacroiliac strain, working efficiency is at a minimum and yet the ordinary pleasures of ambulatory life is not prohibited. Therefore, we must be watchful for any affected symptoms not associated with this condition, never being unmindful of the traumatic types of hysteria and neurosis; we must rule out the sincere from the insincere type of this disorder.

The treatment, of course, is rest, regardless of what form we use or what other adjuncts we may supplement for the relief and control of the symptoms complained of by the patient. This is best obtained by placing the patient in bed, and using the infra-red ray for forty-five minutes daily, or, in the less severe, bed rest is unnecessary and frequently impracticable and rest may be secured by strapping with two-inch strips of adhesive plaster which is imbricated about one-half inch. Strapping should start about two inches in front of the anterior superior spine of the ileum, cross the back to an equal distance in front of the opposite superior spine. The lowest strip should be low enough to grip the glutei muscles and the highest to include the short ribs. This may be renewed when it becomes loosened or about every five days. In some cases, diathermy will produce good results when the infra-red ray has failed. A heavy supportive belt with a pad applied and worn constantly except when the patient is in bed, often allows complete recovery. There are also cases which are truly orthopedic in character and are usually due to faulty posture. These must be treated by orthopedic measures if favorable results are to be obtained. Reduction must be done if there is evidence of a dislocation of the joint and plaster of Paris cast applied for a period of from four to six weeks.

Malingering is difficult of detection and Luss-

kin and Sonnenschein recommend the administration of one-half grain morphine sulphate, hypodermically, at bedtime and if, on arising, the patient claims to have had pain, this precludes that they are dealing with that type of patient.

In acute cases, if treatment is instituted early, the prognosis is good; in chronic cases it is poor and the restitution to normal is very slow. In the majority of cases, recurrences are frequent and troublesome; the wearing of a support in form of a belt minimizes but does not preclude its return. Doubting the advisability of using the word "cure," we can only say that many of these cases progress to a satisfactory recovery while others upon the least provocation reappear with their former complaint and severity. It is said that the open operation cures this condition but because of its chronicity a large majority of these patients drift hither, thither and you in search of relief and finally give credit to the irregular who takes the time to give them physiotherapy and proper support to this disabled joint.

Much of the substance of this paper has been taken from various reprints on this subject, because it is important and the discussion of this condition has been characterized in text books by its absence. Therefore, due credit is hereby given to these authors.

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INADEOUACY OF HOSPITALIZATION FACILITIES*

L. S. LAFFITTE, M.D., Gulf Hammock.

In the few years in which I have been engaged in the practice of medicine, I have been profoundly impressed by the difficulty of obtaining hospitalization for certain classes of cases. I happen to be situated in a county (Levy) which has absolutely no hospital facilities. I am convinced that there is a similar lack in many regions of the State, and that this throws an unjust burden upon other and more enterprising counties or cities in which hospitals are maintained.

Let me disclaim any desire or intention to make harsh criticism of any of the hospitals now in

^{*}Read before the Central Florida Medical Society, Leesburg, February 27, 1931.

existence. When one reviews the history of the rise of these institutions, one must pay homage to the citizens who have accomplished so much.

Nevertheless, I trust that I shall not be committing an offense against good taste if I point out that in thirty-six counties of Florida, representing a population of 273,718, there are no hospitals and apparently little or nothing has been done to arrange for even the most meager hospitalization for the indigent sick and injured.

Florida, with a population of about 1,363,000, has about seventy hospitals, not counting the State Hospital for the Insane and other institutions for custodial care. These seventy hospitals afford about 3,469 beds, giving a ratio of about 393 of

population to each available bed. (Population divided by number of beds.) In the entire United States the ratio is 317. In the South and South Atlantic States the ratio is 539. I am prepared to admit that there are a sufficient number of hospitals in Florida, and perhaps a sufficient number of beds. But I cannot admit that these beds are available for the sick and injured in all parts of the State. The reason for this statement is apparent when a hospital map of the State by counties is inspected. In the accompanying map, each county which has no hospital is indicated by shading. Counties which have hospitals are left in white. To the best of my knowledge, not one of these thirty-six counties without hospitals has



Hospital Map of Florida by counties. Counties without hospitals of any kind are indicated by shading.

any arrangement whereby charity patients can be hospitalized elsewhere. Perhaps there are exceptions of which I am ignorant.

Of the seventy hospitals in the State, there are six which are operated by counties, affording 396 beds. Ten hospitals are operated by municipalities, affording 1,028 beds. Twenty-one hospitals are operated by associations, providing 1,266 beds. Five hospitals are operated by churches, and these have 613 beds. Twenty-eight hospitals are owned by individuals, and these individually controlled institutions have 701 beds. In the statistics here cited, bassinets have been counted as beds. This gives a total bed capacity in the State of 4,004. If bassinets are not included, the total number of beds is 3,469. From these figures it is seen that approximately thirty-five per cent of the beds are provided by governmental institutions, either municipal or county.

The ways and means of keeping the hospitals in operation vary in different cities and towns. In Jacksonville the largest charity institution is the Duval County Hospital, while in Tampa a similar service is rendered by the Municipal Hospital. In Ocala the hospital is supported jointly by city and county. In Gainesville, it is the county which maintains the hospital. In at least one town of which I know, the local hospital, which is operated by an association, sent out solicitors last autumn and asked for donations in kind. These solicitors made a canvass of the town. and gratefully accepted for the hospital donations such as a barrel of flour, a bushel of potatoes, or some chickens and eggs. It is evident that we have not yet decided upon a definite and uniform system for supporting charity hospitals.

I shall now recite one or two instances of how hospitalization sometimes works out in actual practice. In one instance there was an automobile wreck in Levy County. The injured persons were citizens of Levy County, but they were unable to pay hospital bills. Since Levy County has no hospital, somebody took these injured persons to the Alachua County Hospital. There the patients were admitted and treated, since it was the only humane thing to do. Who paid the bill? Not the injured persons; they were without funds. Not the taxpayers of Levy County; the Levy Commissioners were entirely within the law when they admitted no responsibility. The bill fell upon the taxpayers of Alachua County.

One more example. One day last summer I was served a subpoena to go with a sheriff's posse

and a coroner's jury to a trapper's camp on Cow Creek, a distance of some twenty-five miles by motor boat from my office. We made the trip and found a white man who had been shot from ambush. Part of a charge of buckshot had gone through his chest. This man's total earthly possessions were ninety cents in cash and five coon skins. He was a citizen of Levy County. What was done? The County Commissioners authorized a resident of the region to move this wounded man to a cabin near the paved road, some eight miles from the nearest physician, and to give the patient such care as he could, aided by daily visits from the doctor. The man lived ten days in this cabin, and died of sepsis.

It is evident that at present we are simply leaving hospitalization to the various municipalities and counties, and to the churches and hospital associations. In default of a charity hospital in any given locality, the burden of hospitalization of charity cases falls upon hospitals owned by individuals, and these have to negotiate with the local authorities for any financial aid which may be accorded. Enterprising counties which maintain hospitals are imposed upon by less enterprising neighboring counties, or by some of the citizens of such counties. I strongly suspect that charity cases are smuggled from remote parts of the State and dumped in the large cities, such as Jacksonville, in order that these cases may come under the care of the charity organizations.

If we are to improve existing conditions, we must recognize the fact that many of these thirtysix counties which are now without hospitals are rather thinly populated, and lacking in financial resources. Hence the only way in which they can provide themselves with hospitals is by joining together in groups of two or perhaps three or four counties to form hospital districts, uniting their resources to support one centrally located hospital in each district. But to urge this procedure upon some of these counties would be as fruitless as it was twenty years ago to urge some of these counties to build good, paved roads for themselves. We never had a system of paved highways until the building and maintenance of roads was taken out of the hands of the counties and unified under the control of the State. We shall never have an adequate and uniform distribution of even the minimal charity hospitalization facilities necessary to care for the most urgent cases until the problem is recognized by all of the people of the State as something which concerns each and every citizen. The burden of charity hospitalization should fall where it belongs, namely, upon the public.

I wish to offer a suggestion for discussion. My suggestion is for a uniform system of charity hospitals owned and operated by the State of Florida. Let me hasten to make clear that I know the danger of jumping at conclusions. I am aware that the plan which I am putting before you is very imperfect. I believe that no one person could submit a plan which would be acceptable to all. It is my belief that it would be desirable for the problem to be submitted to the criticism of the medical profession, of the hospital administrators, of the public officials, and of the citizens. The subject would require study and discussion for a number of years before any attempt is made to put a new plan into operation.

Briefly stated, my plan would be to divide the entire State into a number of hospital districts. In some thinly populated parts of the State, three or four counties would be grouped together to form a hospital district. In other regions, more thickly populated and already well provided with hospitals, one county could well function as a district unto itself. In the most conveniently located city or town of each district there would be a district charity hospital, operated under a uniform state hospital law. There would be a uniform tax for the support of these charity hospitals, but funds raised in one district would not be available for other districts.

The objection will surely be raised that this is state medicine. Such, however, is not the case. My proposition is nothing more or less than to establish over the entire State, under the guidance of a well-considered State law, a system of hospitals similar in many ways to those which we now have in Ocala, in Gainesville, in Jacksonville, in Bartow, and in Tampa. Under the new plan, just as at present, the members of the medical profession in the region of the hospital would constitute the staff. The principle of rotation would be observed in the various charity services, just as now. There would be no wholesale letting down of the bars to admit individuals for treatment without due investigation of their ability to pay. This problem of how to select charity cases is one which exists at all times, you must admit. It would be necessary to guard against a law which might make it easy for local politicians to influence unduly the selection of charity cases. Moreover, if ever a bill to establish a system of charity hospitals is offered, the public must be made to understand that it is not being asked to vote for indiscriminate, free-for-all hospitalization. The public must be given distinctly to understand that any person who has the ability to pay for medical and hospital services must seek them in the open market, and must pay for these services just as he has to pay for his clothing, his automobile, or any other commodities which he purchases. The support of charity hospitals should fall upon the public, and it is upon this principle that the measure should be carried to the people.

The question arises as to the reaction of private hospitals to such a scheme. It is my impression that at present, in the larger cities where charity hospitals and private hospitals exist side by side, so to speak, the owners of the private establishments are very happy to have in the vicinity a charity institution, for the simple reason that this relieves them of the burden of caring for patients who cannot pay. I must admit that I know of some private hospitals in smaller towns, in which charity cases sent in and paid for by the county commissioners constitute a relatively large source of income. These comparatively small hospitals are doing important work in their communities. In many instances such institutions have been built up by physicians who have devoted much time, money and thought to the betterment of their towns. I certainly do not wish to advocate anything which would bring unfair competition to these institutions. This circumstance constitutes one of the objections to my plan which I cannot answer at present, and to which I wish to call especial attention. That there are other objections, I have no doubt. These objections must be solved after due consideration by all concerned. The solution will require much thought over a number of years.

It is clear that if one wished to compare the present charity hospitalization of the State to the system of highway construction and maintenance which existed in Florida some fifteen or twenty years ago, one would not be far wrong. The analogy is striking. At that time the building and the maintenance of roads were left to the enterprise, or lack thereof, existing in the several counties. That is what we are now doing about hospitals. In 1914 business was undergoing a period of depression. Many people could not then visualize a state-wide system of paved highways. In 1931 business is depressed. Taxes are high. Probably very few people at this time are

in a state of mind which would permit them to pay much attention to problems of charity hospitalization. Yet the implications arising out of a study of existing conditions are clear: either we are satisfied with hospitalization facilities as they are, or we must give thought to improvement of the existing situation.

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EDEMA, A PHYSICO-CHEMICAL IMBALANCE*

ELLIOTT M. HENDRICKS, M.D., Ft. Lauderdale.

Edema may be defined as an increase beyond normal limits of the water content of a tissue. The edema of a tissue is the sum total of the edemas of its component cells. If we find what causes any one of these cells to absorb more than its normal content of water, we have the reason for the edema of the tissue, and further, if we learn how to lessen the water content of the swollen cell without injury to the cell, then we are on the road to a rational treatment of the entire tissue, and on the way to a rational therapy, which should be the aim of every physician.

Let us, then, consider some detached cell which can be easily studied. Blood cells, paramecia and hosts of others will fill our needs. Ameba is a conveniently studied unicellular entity. If we learn what makes an ameba dropsical, and then learn how to cure that dropsy, we have gone a long way toward curing dropsy in the human body. This ameba, like our own body cells, lives in a watery medium. In that water are dissolved salts, nutrient materials and oxygen. The ameba excretes into that water carbon dioxide and other waste products of its living processes. There is a continuous transference of these foodstuffs, salts and oxygen, from the water to the ameba, and the ameba continuously discharges its waste products into the surrounding water. The proportion of water to ameba is great, and this exchange between the water and the ameba can go on indefinitely. However, if we lessen the quantity of water from which the ameba receives its food and oxygen, and into which it discharges its waste

*Read before the 4th Annual Meeting of the Florida East Coast Medical Society, Melbourne, Oct. 2, 1930. products, and seal that water from the air, a new condition arises. The oxygen which has been taken from the water is not replaced, and the oxygen content of the water goes down until there is not sufficient oxygen in the water to fulfill the needs of the ameba. In a like manner, as the ameba excretes its waste products into the limited quantity of water which surrounds it, there comes a time when the concentration of these waste products, or rather the solution tension of these waste products, is as high in the water as in the body of the ameba. Under these conditions, the ameba can no longer excrete its waste products, and they must necessarily remain in solution in the protoplasm of the organism. Due to the lessened oxygen tension within the body of the ameba, foodstuffs are not oxydized wholly, and the keto acids and ketone bodies are formed. Now we notice that the ameba, which had been undergoing normal growth, begins to increase in size with rapidity. We see the beginning of edema in the ameba. In our experiments we take another ameba or blood cell, or a bit of undifferentiated protein such as blood fibrin, and putting that into practically the same environment in which our first animal was studied, we find that other substances besides these waste products which the ameba itself has elaborated, will cause swelling. The chief of these is acids. Comparing various acids of equal ionic concentrations, we find considerable differences in their action. Probably the most active acid is hydrochloric. Following it, a close second, is lactic acid, and then down the line we come to the organic and inorganic acids, until we reach sulphuric acid, under the influence of which very little swelling is noted. On the other hand, alkalies, too, cause swelling, but the swelling produced by alkalies begins at a higher concentration of the alkali and does not, even in high concentrations, equal that produced by acids. Various toxins are used. Diphtheria toxin is particularly potent in causing swellings. The toxins are all related to amines. Histamine shows practically the same effect as a diphtheria toxin. Ammonia and urea are also potent in the production of swelling. The absolute amount of water present makes little difference so long as free water is present for the purposes of absorption.

The analogy of edema in the ameba and the edema of the cell of the tissue, and so on to the edema of the tissue itself, is most complete. Thus, we find that edema of a tissue will result under

the action of certain acids, and certain alkalies, and under the influence of toxic bodies, such as the toxin of diphtheria, and under the influence of various amines and ammonia. The action of these bodies upon the cell itself causes the swelling. The concentration of these various agents in the tissues is ordinarily kept down by the circulation, which leaches them out and carries them to other tissues where they are neutralized by alkalies or acids, or are oxydized to innocuous bodies. In pathological conditions, however, we may have a break in the circulation so that these bodies cannot be carried off as fast as they are formed. This is analogous to the ameba sealed in a limited quantity of water. In addition, when the arterial circulation fails, or the oxygen content of the arterial blood which is fed to the tissues is low, the amount of the oxygen reaching the cells is deficient for its needs, and a production of these unoxydized acids is favored. If there is a venous stasis, the venous blood soon becomes saturated with the carbon dioxide. The solution tension of the carbon dioxide and other waste products in the venous blood becomes as high as the carbon dioxide tension in the cell, and there can no longer be a transference of the waste products from the cell to the blood and so away from the tissue. That this carbon dioxide alone can cause a tremendous edema is shown by the swelling of the red blood cells as they pass from the arterial blood feeding the kidney, through the renal capillaries and so on into the venous circulation. Under these conditions, there is normally an increase of at least fifty per cent in the size of these red blood cells, which swelling comes from the taking on of water. The addition of oxygen does not reduce the swelling, but the washing out of the carbon dioxide as the blood passes through the lungs again, sets free this water, and the cell turgescence subsides. Disease processes ordinarily affect but one or two tissues. Rarely do we find them affecting the whole body. Under certain conditions, however, we may find a generalized edema such as when the kidneys are unable to excrete and we have a gradual retention of the various metabolic waste products, especially urea and ammonia. Under these conditions, we may see an enormous generalized edema. These general edemas are also seen in conditions in which oxidation cannot be carried out. In carbon monoxide poison, a fairly rapid edema is seen, if water enough is supplied to fulfill the wants of the tissues. In inflammations, we see small local-

ized edemas which are no doubt due to the concentration of the toxins in the swollen locality.

We have heretofore considered the cell as a more or less homogenous bit of protoplasm composed chiefly of protein. A more careful inspection of the material with which we are working shows that this is not so. We are really dealing with a colloid system of protein, water, salts, fats, and the various substances of which tissue is made, rather than a homogenous solution. By upsetting the balance which we find this ameba has established for itself, by causing it to take up more water than its normal content, we note the following results: there is first a dilution of the salt content; there is also a dilution of its enzyme concentration and the concentration of such immune bodies as it has elaborated for its own protection. Due to the lowered enzyme activity. we have a generally lowered metabolic activity. It is no longer able to burn its foodstuffs to such end products as can be excreted. Under these circumstances, fixed acids result from partial oxidation, which fixed acids, in turn, increase the water absorbing properties of the cell and further edema results. Because of the dilution and resultant lower concentration of such immune bodies as may be found in the cell, the cell proves a ready victim for various toxins and infections. These, in turn, increase the edema and we have a vicious circle established. Finally, there is a cracking of this emulsion, or colloid state, and the various components of that colloid system begin to appear in particles which are visible. The fat particles particularly are noted by the pathologist, and he calls this stage fatty degeneration. His explanation is that this fat is deposited in the cell from some outside source. Our colloid chemist, however, uses the same explanation that he gives for the appearance of droplets of fat in cracked mayonnaise; namely, a simple aggregation of ultramicroscopic particles into particles of visible size. Death of the cell finally results.

We have shown how edema can be produced in single cells. We may group these cells into a whole and call it a tissue, and we find that the causes for swelling in that tissue are exactly similar to the causes of the swelling in its component cells. Any tissue which suffers circulatory embarrassment, or which is subjected to the action of toxins, or waste products of metabolism in fairly high concentration, will experience an edema, if free water is given it. The edemas fol-

lowing decompensation of the heart, the edemas of general acidosis, the edemas produced by certain venoms, are all explained by the conditions under which we find the component cells. In addition, we find these edematous tissues, just as the edematous cells of the ameba, with a much lowered resistance to infection. Edema of the lower extremities followed by ulcers, edema of the lungs followed by pneumonia, are examples of these. Reducing the edema will increase the resistance of the affected tissue so that it may more ably withstand the assault made upon it by the attacking organisms.

For our treatment of edema, we again take ourselves to the ameba. The ameba which has swollen under the influence of acids, quickly shrinks when a normal alkalinity in the surrounding medium is re-established. Washing the ameba which has been subjected to the influence of various toxins and amines, ammonia and urea, in repeated baths of salt solutions of about normal alkaline concentration, will reduce these to normal limits. The ameba, which we subjected to an alkaline medium, will quickly neutralize that alkali with its own acid products and so reduce its own edema. We find that various salts, even in the presence of high acid, alkali, or toxin concentration, will reduce these swellings. In other words, "we dry our ham by salting it."

These salts do not act according to the osmotic pressure they exert, but seem to have a certain specific property of their own. For instance, the heavy metal salts such as mercury, work in very dilute ionic concentration; especially potent are the sulphates of magnesium and calcium. Sodium and lithium salts are much less potent than these we have mentioned, and ammonium salts seem to increase edema.

When we try to transfer our experiences with the ameba to our treatment of the body as a whole, we meet with numerous difficulties. An analysis of the causes of this edema must be made and an attempt to establish in our own minds which of the various possible causes is the true underlying one. This is fairly easily done if we find a blatant decompensated heart. Here, posture, so that the embarrassed pump will be able to work most efficiently, will do much toward relieving the edema. In order for the kidneys to excrete, this water which has been bound up in an apparently chemical combination with the constituents of the cell, must be set free, and our experience with the

action of the salts on the ameba is very helpful. We find our patient reduces his edema by a good dose of magnesium sulphate, which may be administered either by mouth or intravenously. Each of us has noted that the so-called diuretics also act as cathartics. This they do by setting free, water from the cells and making it available for kidney excretion and excretion into the bowels. Where the edema is due to a retention of protein metabolism products because of an insufficient or inadequate kidney, we find that that kidney often can be made to resume at least a portion of its burden by proper oxygen supply and the action of alkalies and water freeing salts upon its cells. Alkalies and salines by mouth, and intravenously, are to be pushed far beyond the point to which they are ordinarily exhibited. In intravenous administration, care must be taken that these salts, when given in fairly high concentration, are given so slowly that crenation of the red blood corpuscles does not occur, with resultant loss of oxygen-carrying power to the blood, and increase rather than decrease of the edema. Edema of the brain may be treated in the same manner. Sometimes it is wise to allow for better circulation of the brain by drawing off some of the spinal fluid and thereby give more room for blood.

Wherever the edema, and whatever its cause, a plea is made for the more definite determination of that cause. Treating that cause will more often reduce the edema than the empiric exhibition of various drugs offered by the pharmaceutical houses, the use of which is often attended with much danger, as their method of action has not been firmly established.

In conclusion, we wish to point out that all pathological states are primarily those of single cells, or aggregates of single cells, and our treatment, to be rational, should revert back to the basic idea of single cell treatment.

SUMMARY

- 1. A simple pathological condition is described, and its relation to similar pathological states in single cells is pointed out.
- 2. Treatment of the pathological condition in unicellular animals is arrived at, and by analogy, we find the treatment in a more complex organism.

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plete, but a fair insight into the enormous amount of work which has been done along this line may be obtained by consulting these authors. A much larger bibliography and references to earlier papers will be found in their works.

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CHRONIC LEG ULCERS* W. G. MILES, M.D.,

Chattahoochee.

In our class of patients, we see many leg ulcers, the formation of which may be due to varicose veins, traumatism, debilitating diseases, syphilis and the nutritive changes incident to old age.

The most common ulcer, the varicose type, is preceded by a decompensation of the valves situated in the short perforating veins between the superficial and the deep venous systems. These valves are overcome by the weight of the blood column, with resulting stasis and varicosities. The nutrition of the skin becomes impaired and the skin becomes eczematous and dark brown in color from the blood pigment deposits. Trauma usually, but not always, causes the break in the skin. When the skin is once broken, the process of repair is overbalanced by retrograde changes in the tissues and persistent ulcers result. The causes that produce the ulcers perpetuate them.

Chronic ulcers pass through three states: (1) extension; (2) a latent phase, in which there is neither extension nor repair; and (3) repair.

In the first stage, there is a marked edema and increased local heat, and a definite inflammatory process is set up. There is usually breaking down of the skin and superficial tissues, followed by a profuse, thin, irritating discharge. During this state, the lymphatics become obstructed and the normal current of tissue juices is reversed, which adds to the necrotic slough.

The second stage presents the picture of chronicity, with sharp, well defined edges, extremely hard and painful. The base adherent to the underlying structure is covered with a gray-green tenacious exudate, and no granulations can be seen. The discharge has a foul odor and a thick consistency and is somewhat irritating. The second

stage has been called the indulent or callous ulcer. The secondary infection is at its maximum in this stage.

The third stage is essentially a process of healing. The edges are soft and smooth and are light pink; the base is smooth and dark pink. Granulations which bleed easily can be seen throughout. Pain is not present. The discharge is of a serous nature and is abundant. In this stage the lesion has been described as a "weeping ulcer." Again, there is the lymphatic flow and admixture of tissue juices, with only slight infection.

TREATMENT

Knowing the pathologic condition described, one must demand in a satisfactory method of treatment, care of the ulcerative lesion and support of the failing circulation of the leg. These ends are better attained by some of the advocated procedures than by others. Martin's red rubber bandage has been extensively used and has proved itself one of the best forms of treatment, but its application is difficult and frequently results in destruction of the superficial tissues of the leg. The spiral reverse pressure bandage of heavy linen described by Doris is probably the best form of bandage. The A. C. E. bandage of knit elastic is also widely used. The rubber stocking made of similar material lends support to the circulation of the leg and to the ulcer, but after a short period of time there is atrophy of the superficial tissues and general discomfort.

It has been my custom in the treatment of chronic leg ulcers to first treat the cause, if one is present. Then cleanse the ulcer and surrounding tissue with tincture of green soap, dry and apply insulin freely, with applicator, to the surface of the ulcer. Then cover surface of ulcer with a 10% ointment of insulin, using laualin or white petroleum as a base. Apply a support and keep the patient in bed with leg elevated. I have found that best results are attained by going through this routine daily.

Leg ulcers which have been treated only by support have healed, but not with such rapidity as the ones treated with insulin, insulin ointment and support. Insulin is not a panacea for all chronic leg ulcers but its daily application, or 10% ointment, brings about healing in a most satisfactory manner.

^{*}Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Chattahoochee, October 10, 1929.

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John E. Doro, M.D., Chairman (Term expires Ma-	у, 1	932)	
		J	ack.	sonville
R. O. LYELL, M.D., (Term expires May, 1933) .				Miami
John S. Helms, M.D., (Term expires May, 1934)		,		Tampa
				-

AMERICAN MEDICAL ASSN.—HOUSE OF DELEGATES

				, Delegate							
C.	D.	CHRIST, I		Alternate .							Orlando
			(Ternie evnir	0 N	fav	10	139)			

PRESIDENT'S SPECIAL APPOINTMENTS REPRESENTATIVE, FLORIDA COUNCIL ON HEALTH,

			WELF	ARE	AND	EDU	CATIO	N.			
H.	MASON	SMITH,	M.D.								Tampa
	ADV	ISORY	COM	MITTI	EE TO) WO	MAN'S	At	JXILI	ARY	7
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L. M. ANDERSON, M.D.,						
WM. P. ADAMSON, M.D.	 		,	,	,	Tampa
F. CLIFTON MOOR, M.D.						Tallahassee
J. H. PIERPONT, M.D.	 					 Pensacola
FREDERICK J. WAAS, M.						

PRESIDENT'S SPECIAL APPOINTMENTS (Continued)

PUBLIC RELATIONS COMMITTEE (Auxiliary to Executive Committee)

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J. RALSTON WELLS, M.D.,	S	ecre	tar	у.			Day	ona	Beach
J. M. IRWIN, M.D							St.	Au	gustine
J. S. McEwan, M.D								. (Irlando
ERNEST B. MILAM, M.D.							.]	acks	onville
HENRY E. PALMER, M.D.									
W C. PAYNE, M.D								Pei	nsacola
HOMER L. PEARSON, M.D.									Miami
J. A. SIMMONS, M.D								. /	Arcadia
H. MASON SMITH, M.D.							٠		Tampa

REPRESENTATIVES, GEORGIA MEDICAL ASSOCIATION

RALPH N. GREENE,	MD.						J	acksonvil	le
ROBT. C. WOODARD,	M.D.					٠		. Mian	ni

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FIRST DISTRICT-I. M. HOFFMAN, M.D., Okaloosa, Walton, Santa Resa, Escambia.	Pensacola
SECOND DISTRICT O C VINNER OF M.D.	Tallahassas

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THE WORK OF CANCER CONTROL IN NEW YORK

During 1929, the death rate from cancer in New York was 129.4 per 100,000 of population, a very large increase as compared with 1901, when the rate was only 69.3. These are very striking figures, and would be most alarming, if it were not possible to balance them with statements of what is being accomplished in the fight for cancer control.

First, it must be understood that cancer is not an incurable disease. When this is thoroughly grasped much will have been accomplished. In EDITORIALS 33

many cases the disease can be arrested by proper treatment; but it is of the utmost importance that this treatment be begun early. The most skillful doctor with the most effective remedies can accomplish but little if his help is not asked for until the patient is in a far advanced stage of the disease. The American Society for the Control of Cancer has for its object the enlightening of the public as to the facts about cancer and the first symptoms of the disease, so that the patient, recognizing the early warning signs, will seek a diagnosis and treatment at once, and be assured of the best chance for escape.

In New York and its immediate environs this work of public cancer education is under the direction of the New York City Cancer Committee of the American Society for the Control of Cancer, which maintains a permanent office at 34 East 75th Street. From this office the committee sends out pamphlets carefully compiled so as to convey accurate information to the lay person.

There are many other mistaken ideas about cancer, the correction of which will do much to relieve the burden of dread imposed by the disease. There is, for instance, the belief that cancer is "catching." This is a belief that has worked hardship on many sufferers who by reason of it were deprived of the personal care and attention of their families. In some instances, it has been possible to furnish such definite proof that cancer can not be given by one person to another as to remove all doubt regarding the advisability of keeping a sufferer at home. Hospital treatment is, of course, imperative in most cases, but when all that is possible has been done and cure is out of the question there is no reason why the patient with cancer, as well as the patient with other chronic non-contagious diseases, should not have the comfort of family care in the later stages of the disease.

This and other information of the same sort is contained in the pamphlets referred to, one of which, "What Every Woman Should Do About Cancer," after being written in English, has been translated into French, Spanish, Italian, Yiddish, Russian, Polish, and Slovak. Copies of all of these are available for distribution, free of charge, to anyone desiring them. A small leaflet carrying a list of the danger signals of cancer has been printed in twenty-two different languages. Requests for either of these in small or large quantities may be made directly to the New York City Cancer Committee.

OUR DELEGATES' REPORTS OF EIGHTY-SECOND ANNUAL MEETING, A. M. A., PHILADELPHIA

The House of Delegates has a total voting membership not to exceed one hundred seventy-five. The members are proportioned from the various constituent organizations of the American Medical Association, which is evidence of equal representation:

1			
Alabama	3	New Hampshire	1
Arizona	1	New Jersey	4
Arkansas	2	New Mexico	1
California	6	New York	15
Colorado	2	North Carolina	3
Connecticut	2	North Dakota	1
Delaware	1	Ohio	7
Dist. of Columbia	1	Oklahoma	3
Florida	2	Oregon	1
Georgia	3	Pennsylvania	11
Idaho	1	Rhode Island	1
	10	South Carolina	2
Indiana	4	South Dakota	1
Iowa	3	Tennessee	3
Kansas	3	Texas	5
Kentucky	3	Utah	1
Louisiana	2	Vermont	1
Maine	2	Virginia	3
Maryland	2	Washington	2
Massachusetts	6	West Virginia	2
Michigan	5	Wisconsin	3
Minnesota	3	Wyoming	1
Mississippi	2	Alaska	î
Missouri	5	Hawaii	1
Montana	1	Isthmian Canal Zone.	1
Nebraska	2	Philippine Islands	1
Nevada	ĩ	Porto Rico	1
Practice of Medicine		TOTO RICO	1
			_
Surgery, General and A	Abdom	inal	1
Obstetrics, Gynecology	and A	bdominal Surgery	1
Ophthalmology Laryngology, Otology a			1
Laryngology, Otology a	nd Kh	inology	1
Diseases of Children			1
Pharmacology and The	rapeut	ics	1
Pathology and Physiolo	gy		1
Nervous and Mental D	iseases	3	1
Dermatology and Syphi	lology		1
Preventive and Industria			1
Urology			1
Orthopedic Surgery			1
Gastro-Enterology and			1
Radiology			1

Florida has two delegates who were in attendance and voting at the Philadelphia session.

The first meeting was called to order Monday morning, June 8th, 10 a. m., by the Speaker, Dr. F. C. Warnshuis. The House, in which is transacted the business affairs of the Association, under the able leadership of the Speaker, is undoubtedly the smoothest executive body in the medical world.

The Philadelphia County Medical Society invited the delegates to a dinner and an interesting program in the evening.

PROGRAM

Address of Welcome, George P. Muller, M.D., President, the Philadelphia County Medical Society. Five Minute Addresses, William Gerry Morgan, M.D., President, American Medical Association; E. Starr Judd, M.D., President-elect, American Medical Association; Olin West, M. D., Secretary, American Medical Association.

"Philadelphia as a Medical Center," George E. DeSchweinitz, M.D., former president, American Medical Association.

"Philadelphia and Its Traditions," Hon. Roland S. Morris, former U. S. Ambassador to Japan. Dr. E. Starr Judd, President-elect, in his address stated: "The American Medical Association is not only the largest but the most democratic and influential medical association in the world. As such, the responsibilities are enormous. One of the chief duties of the House of Delegates is to elect the officers of the Association and the members of the Board of Trustees. Only by close association with the Trustees of the Association can one fully realize the importance of

The Secretary's report showed a total membership of 100,200, of which there were registered in Philadelphia 7,006. These figures constituted the largest enrolled membership in the history of the organization. The Philadelphia registration may be attributed in part to the central location. But it is very evident that the doctor should be congratulated on his optimistic faith in the future business outlook.

keeping these positions filled by capable, conscien-

tious men, regardless of politics or of friendship."

Space will not permit, neither is it necessary to attempt to reproduce the proceedings in Philadelphia, as the details may be obtained from the publications of the Association.

Philadelphia's Municipal Auditorium housed the Scientific Assembly, the Scientific and Technical Exhibt. The Scientific Assembly, composed of more than three hundred papers, naturally discussed virtually all phases of the progress of medicine in general, which, too, will appear from time to time in the pages of the Journal.

The Scientific Exhibit occupied a floor space of approximately 32,000 square feet—by far the largest amount of space ever occupied by the Scientific Exhibit. Admission was limited to regularly enrolled Fellows or guests of the Association wearing badges, and was not open to the public.

The Technical Exposition presented developments from the commercial exhibit a quarter of a century ago. These exhibits are rapidly changing each year from a simple commercial proposition to a kind of selling event, which is based on genuine service to the medical man. The program of the Technical Exposition demonstrates more and more of an informative or an educational contribution.

The Sessions of the House of Delegates are very essential for the continued progress of organized medicine and materially concerns the individual practitioner as well as each and every medical society.

The State's delegates may obtain a great deal for their group by faithfully attending the Sessions, consuming much of their time which, of course, is necessary, as it applies in this instance that no more can be gotten out of a thing than is put into it—each Session.

Your delegates recommend to the membership to carefully study the proceedings of the Philadelphia meeting as will be published in the American Medical Association publications.

Will you also be good enough to note the following facts and govern yourself accordingly:

There are sixty-seven counties in Florida, nineteen of which are not organized and there are thirty-five component societies. Seventeen hundred seventy physicians are registered in Florida, of which one thousand three are members of the State Association, with only five hundred twentyseven fellows of the American Medical Association. Eight hundred forty-seven, or only fortyseven per cent of the doctors in Florida receive the Journal of the American Medical Association. (Signed) Bundy Allen, M.D.

Your delegate to the American Medical Association Convention attended all meetings of the House with great regularity. Being somewhat of a stranger and also due to the fact that there were present numerous and willing speakers who would talk on all motions, he took no part in discussions.

The meeting of the first day devoted to organization, hearing preliminary committee reports and the introduction of new business, was especially a busy day for your delegate as he sat on the Credentials Committee. This phase of the convention was made doubly arduous by the physicians' seeming indifference toward their credentials—many being lost or left behind, and failure to properly endorse if and when they were turned over to the alternate.

One thing which struck the writer forcibly was the presence of a majority of the same men whom he met when he sat in the house five years ago—able men who have been returned year after year by their State Societies, men who know the history and dream of the future of organized medicine as represented by the American Medical Association.

The crop of new resolutions was enormous but were expedited on their way by the masterful handling of all delicate situations by our speaker, F. C. Warnshuis.

The only profound change in the constitution which provided for seating in the House a delegate from the Veterans' Bureau, brought out much active discussion and it became so direct on both sides, that a motion to table was easily carried.

A resolution sponsored by the Michigan State Medical Society providing that since filling out death and accident claims often require expert medical knowledge, the burden of expense should be placed upon the insurance company and not the relatives of the patient, was reported to committee to be studied and reported on later. The committee later reported unfavorably because there were so many states having conflicting laws that this act would have no legal status. Another resolution provided for a committee on qualifications for specialists to study and define qualifications in conjunction with the committee on Medical Education and hospitals and report next year.

Several resolutions, almost identical, which were presented regarding the limitation of a legalized physician's efforts to heal the sick as is reflected in the Volstead Act, were adopted and the Secretary instructed to send copies of it to Congressmen and constituent societies asking for their support.

The Technical Exhibition was complete as usual, over 190 firms being represented, every article known to medical science being on display.

The Scientific Exhibit was a marvel of completeness, over 32,000 square feet of floor space being used. One could have spent the entire week there gaining hourly valuable information which could be put into daily use in one's general practice—a most complete post-graduate course.

The last session was devoted almost entirely to election of officers, trustees and place of meeting. Dr. Cary of Texas was unanimously made President-elect, as were the other officers save that of vice-speaker of the House. The contest between Bulson of Indiana, the present incumbent, and Cord of New York was decided in favor of Bulson.

The Secretary reported that preliminary canvas showed that San Francisco met all the requirements of the place for 1932 meeting and that New Orleans was better provided with space than was Memphis. The vote was overwhelmingly for New Orleans.

(Signed) G. H. EDWARDS, M.D.

CORRESPONDENCE

From Past President J. C. Davis, June 30, 1931.

I firmly believe that we should have a Presidentelect of the Florida Medical Association. The year before the president assumes office he would have an opportunity to familiarize himself with his duties and the needs of the organization, and should prepare his address during his elect year. This address should be delivered when he is inducted into office instead of when his term of office expires as at the present. This year of preparation for the presidency would also give the various committeemen time to familiarize themselves with their supposed duties in order that they might assist the president in endeavoring to carry out any worth while policies advocated in the Presidential Address. As Past President, I fully realize that I was just beginning to learn the duties of the office when the year was out. I feel that organized medicine and the Florida Medical Association would be benefited by having a Presidentelect.

(Signed) Julius C. Davis.

From Chairman Hospital and Medical Education Committee, J. E. Boyd, June 24, 1931.

Your editorials discussing a "President-elect" seem to me timely. I am not disregardful of any time-honored custom that preserves the antiquity of our association. At the same time, I am for any change that will be of help to our officers in carrying on its business. No laws ever have been written that provided for all the changes due to the advance of time. Surely, it is the desire of all of us to promote the interest of our association, so if the time has come when a "President-elect" will accomplish that much-to-be-desired end, then I am one hundred per cent for it. I repeat that I am convinced that the editorials seem to me timely. I see no possible objection to the necessary changes in our by-laws.

(Signed) JOHN E. BOYD.

STATE NEWS ITEMS

The State Board of Medical Examiners held its examination in Jacksonville on June 15th and 16th, at which time the applications of thirty-seven applicants were approved for examination Two applications were turned down on the ground that the applicants graduated from colleges of low rating.

The licenses of four doctors were revoked on the following grounds:

Dr. E. K. Tullidge, Miami, for having violated his oath in making application before the board—saying he had never been convicted of a crime involving moral turpitude.

Dr. John H. Banks of Miami for violation of the Harrison Narcotic Act.

Dr. D. B. Harvey of Mount Dora for having been convicted in Indiana for first degree murder.

Dr. Paul C. Ronning of West Palm Beach for having fraudulently received his medical license and diploma.

The names of the applicants who appeared before the Board are as follows:

Anderson, James L Cross City
Anderson, Ruskin G
Bernier, L. J
Boynton, Charles E., Jr
Brown, Andrew George
Burnett, Paul C., Jr
Castellano, Juan E. HernandezTampa
Cheney, Raymond O Lake City
Cleveland, Jack QAtlanta, Ga.
Cram, George EPalm Beach
Dees, J. H
Dell, J. M., Jr
Dunne, Harold E
Edwards T I
Edwards, T. J
Grace, Charles CPittsburg, Ga.
Graves, L. J
Hendricks, W. H
Henley, Charles FJacksonville
Hinton, Andrew HillMiami
Laymon, Russell L Miami
Light, Kermit AMiami
McCormick, William M Miami
McDonald, C. W DeFuniak Springs
Mayher, W. E., JrColumbus, Ga.
Mentzer, Claude G
Monat, Henry ALake City
Morlan, Eldridge RAuburndale
Morris, Neal Lake City
Myers, Edward L
Oberdorfer, Arron Z Jacksonville
Pepper, MaxMiami
Quicksall, John BSt. Petersburg
Ryan, Harold
Scott, Stuart
Spitz, Eugene I
Sutter, L. M Orlando
Teasley, Gerald HAtlanta, Ga.
reasity, Octain II

A most interesting meeting of the Public Relations Committee which is an auxiliary of the Executive Committee was held at Ocala, July 5th.

Those attending the meeting were Doctors G. H. Edwards, H. C. Dozier, J. S. McEwan, J. A. Simmons, J. M. Irwin, J. Ralston Wells, Homer L. Pearson, Gerry R. Holden and Stewart G. Thompson. A complete report of the committee meeting is being prepared by Dr. J. Ralston Wells and will appear in next month's Journal.

* * *

The enacting of the county health unit bill into a law in Florida signifies a definite step of progress in health work. Recently, the following statement was made by Surgeon General Hugh S. Cumming, M.D., "The practicability and value of local whole time health service conducted through county health departments have become definitely established and it is now generally recognized that the health matters of a community can be best administered through an official local health organization with a competent whole time public health director at its head."

* * *

Dr. James T. Cowart of Tampa is taking a post-graduate course at the Manhattan Eye, Ear and Throat Hospital in New York City.

* * *

Dr. J. S. McEwan of Orlando and his son motored through Jacksonville recently. Dr. Mc-Ewan's many friends in Jacksonville were delighted to see him, although his stay was very brief.

* * *

Dr. C. D. Whitaker of Raiford attended military camp at Fort Barrancas, Florida, for two weeks during the month of June.

ROBERT S. LOWRY

Dr. Lowry was born in Butler, Pennsylvania, January 14, 1880. He received his medical education in Philadelphia and at Lehigh University. He moved to Ft. Lauderdale in 1910 where he made his home until in the summer of 1930 when he left Florida to take up practice at Kingsville, Ohio. He enlisted in the Navy during the World War and was in naval service eight years.

Dr. Lowry became ill with pneumonia on December 30 and passed away on February 23rd. He is survived by his wife and one son, Robert K. Lowry. He was buried at Butler, Pennsylvania, his birth place.

At the recent meeting of the American Medical Association in Philadelphia, the following officers were elected for 1931-1932:

President-elect-E. H. Cary................. Dallas, Texas Vice-President-George C. Yeager Philadelphia Chicago Secretary-Olin West Treasurer-Austin A. Hayden......Chicago Speaker of the House of Delegates-

Frederick C. Warnshuis Grand Rapids, Mich. Vice-Speaker of the House of Delegates—

Albert E. Bulson Fort Wayne, Ind. Board of Trustees-Thomas S. Cullen......Baltimore (Term expires, 1936)

Judicial Council-Walter F. Donaldson.....Pittsburgh (Term expires, 1936)

Council on Medical Education and Hospitals-

Dean LewisBaltimore (Term expires, 1938)

Council on Scientific Assembly-

John E. Lane..... .. New Haven, Conn.

(Term expires, 1936)

The total registration for four days was 6,828. The members of our state association who were registered as officially attending the meeting are as follows:

Allen, Bundy (Delegate)	
Andrews, L. L.	Orlando
Barge, H. A.	Miami
Clark, Samuel Allen	Lakeland
Cowart, J. T	
Echard, Thos. B	St. Petersburg
Edwards, G. H. (Delegate)	Orlando
Fletcher, E. Gordon	St. Augustine
Fox, Harold H	Miami
Foxworthy, F. W	Miami
French, Elmo D	Miami
Halton, Jack	Sarasota
Hendricks, Elliott M	Ft. Lauderdale
Hodges, J. H	Gainesville
Hodsdon, B. F.	Miami
Ingram, L. C.	Orlando
Knowlton, Roscoe H	St. Petersburg
Koon, A. C	Lakeland
Martin, L. W.	Sebring
Maxwell, Eugene B	Miami
Mills, Herbert R	Tampa
Post, William G., Jr	
Quillian, Warren	Miami
Robinson, Leigh F	
Ross, William E	
Rutter, Joseph H	
Shaw, W. M	Jacksonville
Simmons, Samuel J	Clewiston
Spicer, Robert T	Miami
Taylor, H. Marshall	Jacksonville
Taylor, Joseph W	Tampa
Timberlake. Gideon	St. Petersburg
Warren, William R.	Kev West
Westcott, William E	Orlando
Wilhoyte, Roy E	Lake Wales
Williams, Carl A	St. Petersburg
Wood, A. J.	St. Petersburg
Youmans, Iva C	Miami

The next annual meeting will be held in New Orleans, Louisiana.

Born to Dr. and Mrs. J. B. Dowling of Alliance, a girl, Patsy Lorena Dowling, on May 5, 1931.

Dr. and Mrs. C. R. Wilcox of Jacksonville recently motored to Palm Beach and St. Petersburg.

Dr. W. H. Daniels of Miami has gone to Baltimore, Maryland, where he expects to practice.

The Florida Medical Association was well represented at the recent meeting of the American Medical Association in Philadelphia. Thirtyeight (38) of our members were in attendance.

Dr. W. E. Ross of Jacksonville, chairman of the Duval County Medical Milk Commission, recently attended the national convention of the American Association of Medical Milk Commissions in Philadelphia.

The Jackson County Medical Society met in regular session June 9, 1931, at the Chipola Hotel. Marianna. After having dinner, a very interesting program was entered into by those present.

Dr. and Mrs. Stephen Gyland, Brewster, announce the birth of a daughter on June 9, 1931.

Dr. S. D. Rice of Gainesville died at his home June 21, 1931.

The Dade County Medical Society held its regular meeting Friday, June 5th. The scientific program included a paper on "Laboratory Control and Syphilis Treatment," by Dr. Joseph Matthieu and a paper on "Differentiation between Leprosy and Tuberculosis," by Dr. John Ritter. Presentation of lantern slides showing various manifestations of lesions added to the interest of the paper.

In the printed program prepared by the Dade County Society there appears a timely little editorial by Dr. Homer L. Pearson, president. This editorial, while very brief, was spicy and contained many items of particular interest. Dr. Pearson informed the membership of Dade County Society regarding what was missed by those who did not attend the previous meeting, commented on the meeting of the Florida Medical Association at Orlando urging support of President Edwards and bringing out points of interest to Dade County Society. As an echo of the meeting we will quote one line from this editorial which indicates the enthusiasm with which the entire editorial was prepared: "So it is our duty to put our shoulder to the wheel and push whenever we are called upon to do so."

Dr. James L. Estes, Tampa, recently attended the American Urological Association meeting which was held in Memphis, Tennessee. Dr. Estes returned by way of Atlanta where he visited clinics for several days before returning to Tampa.

* * *

Dr. C. L. Davis of Okeechobee was recently elected president of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society and Dr. J. D. Parker of Stuart was selected as secretary. There is every indication that Dr. Parker is going to be a live secretary as he has already contacted the business office.

* * *

Dr. A. B. Cannon entertained the Pasco-Hernando-Citrus County Medical Society Thursday evening. June 25, in his home at Lacoochee, Flor-The hostess, Mrs. Cannon, in her usual charming manner, served a delicious dinner of roast duck, combination salad, snap beans, potatoes, hot biscuits and coffee, followed with ice cream and cake. After the dinner, Mrs. Cannon invited the ladies to play bridge while the doctors retired for their scientific discussions. Dr. Cannon gave one clinical report with a patient present together with three other clinical reports. Drs. Bradshaw and Jackson each gave two case reports which were discussed by all doctors present. The meeting adjourned with many kind expressions to the host and hostess for a most delightful evening spent in their home. The next meeting will be held with Dr. Creekmore in Brooksville next month.

CLARENCE T. SKIPPER

The Florida Medical Association regrets the death of Dr. Clarence T. Skipper of Jacksonville on May 26, 1931. Dr. Skipper was a graduate of the Atlanta College of Physicians and Surgeons in 1909 and entered practice of his profession at Pelham, Georgia, soon after his graduation. He removed to Jacksonville 18 years ago, where he has practiced his profession up to the time of his death, which was the result of pneumonia.

He was a member of the Duval County Medical Society, the Florida Medical Association, many fraternal organizations and the Baptist Church.

All of the 203 applicants who took the examination for trained nurses, held at the Seminole Hotel in Jacksonville June 2-4, passed successfully with Mary Magdaline Gardner of Orlando and Sister Cecelia of Pensacola tying for first place honors. Nine graduates from other states took the examination, all passing with creditable marks. Records were also compiled showing the number of representatives of various hospitals who took the examination. Gordon Keller of Tampa led with 35 nurses present who finished with a combined average of 90.38.

In accordance with the agreement between the New York Post-Graduate Medical School and Hospital and Columbia University, effective July 1st, by which the former becomes the Post-Graduate School of Medicine of Columbia, an Administrative Board of Post-Graduate Studies in Medicine has been established by President Nicholas Murray Butler, on which will be represented members of the governing body of the University, the undergraduate medical school and the post-graduate school of medicine.

Under the terms of the affiliation, this Board will have general oversight and control of all post-graduate instruction in medicine offered by the University, whether at the Medical Center, the Post-Graduate Medical School or elsewhere in the city, and is constituted as follows: Dean Willard C. Rappleye, chairman; Dr. Linsly R. Williams, Dean Howard Lee McBain, Director James C. Egbert, Dr. Walter W. Palmer, Dr. James W. Jobling, Dr. Frederick Tilney, Dr. Arthur F. Chace, Dr. Herman O. Mosenthal, Dr. Howard F. Shattuck, Dr. Edward H. Hume, Dr. Harry S. Dunning, Dr. Lewis F. Frissell, and Mr. Frank D. Fackenthal.

On nomination of President Butler, the Trustees of the University have appointed Dr. Edward H. Hume, as director, and Dr. Alan R. Anderson, as Associate Director of the New York Post-Graduate Medical School.

This incorporation of the New York Post-Graduate Medical School into the teaching system of Columbia University as its post-graduate school of medicine, distinct from the undergraduate school, carries into fruition, after some fortynine years, the ambition of the seven founders of the Post-Graduate who resigned from the faculty of the New York University upon the refusal of the Trustees to grant them a separate building for post-graduate instruction and, early in the year 1882 organized the present New York Post-Graduate Medical School and Hospital.

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Formerly Assistant Professor of Nervous and Mental Diseases, University of Wisconsin. Clinical Professor of Nervous and Menta Diseases, George Washington University. Associate Professor of Clinical Psychiatry Georgetown University, Washington, D. C.

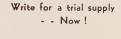
No modification necessary...

t is not necessary to further modify S.M.A. for normal full term infants, for the same reason that it is not necessary to modify breast milk - for S.M.A. contains the essential food elements in proper balance. Because of this close resemblance to breast milk, the very young infant can tolerate the fat as well as the other essential constituents of S.M.A. and it is possible to give it in the same strength to normal infants from birth to twelve months of age.

As the infant grows older, therefore, it is only necessary to increase the total amount of S.M.A. diluted according to directions.

Orange juice, of course, should be given the infant fed on S.M.A. just as it is the present practice to give it to breast fed infants, to supply an adequate amount of the anti-scorbutic vitamin "C".

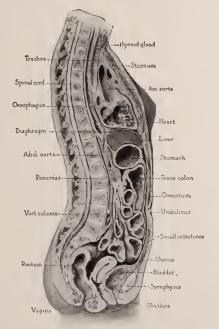
TRY S. M. A. AT OUR EXPENSE





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MEDIAN SAGITTAL SECTION OF FEMALE TRUNK Vertical sections through the trunk are valuable in showing the relationship of the various organs of chest, abdomen, and pelvis to each other.

for the Practitioner

A Set of Anatomical Studies (in book form) furnished to physicians on request — upon receipt of 20c to cover mailing costs.



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WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS, EDWARD JELKS,

2244 St. Johns Avenue
lacksonville

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REPORT OF THE PHILADELPHIA CON-VENTION OF THE WOMAN'S AUX-ILIARY, A. M. A., JUNE 8-12. Mrs. J. Ralston Wells.

I can only attempt to report to you some of the high lights of the Philadelphia convention. It was so overwhelmingly successful, so efficiently managed, and so delightfully entertaining, that it is more than one poor delegate could comprehend, much less report in full.

To begin with, there was the largest attendance of women ever recorded. One thousand one hundred and three were registered—69 delegates, 21 alternates, 540 members, and 473 guests. This was the registration as reported on Wednesday, June 10.

Though the convention proper was not officially opened until Tuesday morning, June 9, the previous day was a very full one. Activities began with a buffet luncheon in honor of the National Auxiliary Presidents, eight in number, and only two were absent. This was followed by

DRUG ADDICTS

Drug and Alcoholic patients are humanely and successfully treated in Glenwood Park Sanitarium, Greensboro, N. C.; reprints of articles mailed upon request. Address W. C. Ashworth, M.D., Owner, Greensboro, N. C.

a series of round table conferences on the subjects: Programs for County Auxiliary Meetings; The Technique and Value of a Committee on Public Relations; and History and Archives. This was perhaps the most interesting meeting of all, for it led to informal discussion of our problems and individual methods of solving them. In the absence of the scheduled leaders, I had the honor of presiding over the first conference and I wish I might tell you of all the interesting discussion. The majority reported county programs of a social nature, with emphasis on food, but a growing disposition to self-education and outside activities. This seems to be the normal evolution of every auxiliary.

The National Board dinner was held Monday evening, followed by the Pre-Convention Board meeting. Since the consideration of the budget, election of a nominating committee, discussion of revisions, and other business came before this meeting, it lasted till the wee small hours.

The Ninth Annual Convention was called to order by the President, Mrs. Hunsberger, at 9 a. m., Tuesday, June 9th. The annual reports of officers and chairmen of standing committees were given this morning. They were particularly interesting in showing the growth of our organization. You will be interested to know that we have over 12,000 paid-up members and our income for the past year was \$5,338.13 and expenses up to April 1 were \$3.087.69. Another annual report in which Florida should be especially interested was Hygeia. Our State ranked fourth and Mrs. Herbert, chairman, paid special tribute to the work of our Hygeia Chairman, Mrs. Herrman Harris. Considering our small membership, this is a record of which we should be proud.

The bright spot of the Wednesday meeting was the State Presidents' reports. Most of these were very stimulating and even those who had no outstanding activities to report showed an awakened interest and promise for the future. The report of the nominating committee was unanimously adopted and after the new officers were introduced the convention was adjourned.

The post-convention Board meeting was held (Continued on page 42)

SITUATIONS WANTED

Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians' Exchange, 30 North Michigan, Chicago. Established 1896. Member The Chicago Association of Commerce.

IN INFANT FEEDING if you are using lactic acid milk Dextri-Maltose is the Carbohydrate of Choice

because it is dry, easy to measure, bacteriologically clean, unattractive to flies and dirt, being prepared exclusively for pediatric use by a natural diastatic action instead of an acid hydrolysis process. Moreover, long clinical experience indicates that Dextri-Maltose is the most easily assimilable of all carbohydrates, least likely to cause nutritional disorders.

* * * *

For the convenience of physicians who desire to employ lactic acid milk with Dextri-Maltose, there is available MEAD'S POWDERED Non-Curdling LACTIC ACID MILK NO. 1 (with Dextri-Maltose)

This product offers several practical advantages: (1) It is more simply prepared for the mother than fluid lactic acid milk—with less danger of error. (2) It is uniform in composition. (3) It is practically sterile, but may be boiled without curdling. (4) It is economical because there is no waste. (5) It is convenient for the traveling mother, as no refrigeration is required.

* * * *

For physicians who appreciate the advantages of the powdered form over the fluid form of lactic acid milk, but who prefer to make their own carbohydrate additions, there is also available

MEAD'S POWDERED Non-Curdling LACTIC ACID MILK
NO. 2 (without Dextri-Maltose)

These three Mead infant diet materials are for sale at drug stores—without dosage directions and are advertised only to physicians.

Mead Johnson & Co. INFANT DIET MATERIALS Evansville, Ind., U.S.A.

Thursday morning, presided over by Mrs. Mc-Glothlan, followed by a general round table conference at which the new president outlined her policies for the coming year in a very able manner, and announced her committee appointments. The opening of a question and suggestion box brought forth much interesting discussion and a number of women spoke very ably on the subject "What have I gotten out of the convention?" A stimulation of interest and enthusiasm could not fail to follow such a meeting.

It is not possible for me to tell about the many side trips nor delightful entertainments furnished by our hostesses. Not only did Philadelphia entertain us, but Pennsylvania. New Jersey and Delaware joined her in making our stay a neverto-be-forgotten one.

Most attractive souvenir programs were given all women and I secured enough additional ones to be able to send one to each Auxiliary in Florida, which I shall do, that you all may see better than I can tell you, just how nice it all was.

FLORIDA AUXILIARY HONORED AT NATIONAL CONVENTION

Florida was signally honored at the National Convention in Philadelphia, in having our Past President, Mrs. J. R. Wells, of Daytona Beach, elected third vice-president. The newly elected national offices are as follows: President, Mrs. A. B. McGlothlan, St. Joseph, Mo.; president-elect, Mrs. W. J. Freeman, Philadelphia, Pa.; first vice-president, Mrs. James Blake, Hopkins, Minn.; second vice-president, Mrs. J. F. Percy, Los Angeles, Cal.; third vice-president, Mrs. J. R. Wells, Daytona Beach, Fla.; fourth vice-president, Mrs. R. W. Tomlinson, Delaware; recording secretary, Mrs. S. S. Hesselgrave, St. Paul, Minn.; treasurer, Mrs. G. H. Mundt, Chicago, Ill.

* * * Duval County

Duval County Auxiliary held its last meeting, until next fall, on Thursday morning, June 4th, at 10 o'clock in one of the parlors of the Seminole Hotel. In the absence of the President, Mrs. Kirk, Mrs. S. E. Driskell presided. Mrs. Driskell's splendid report of the State Meeting in Orlando, was gives by Mrs. Veal, the secretary.

Mrs. Herrman Harris, State Chairman of Hygeia and a member of the National Committee on Hygeia, was present and reported that Florida ranked first among the states of the South Atlantic

(Continued on page 44)

Any one can make belts, but belts which give compression without uplift may do serious injury

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Pleases doctors and patients. Long laced back. Soft extension, low on hips. Hose supporters attached.

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FUL-VUE FRAMES are attracting a good deal of attention — most people are quick to recognize the improvement made by the high temples, the new eyeshape and the pads that rest on the sides of the nose.

Your patients expect you to wear the newest and best in glasses. Are your glasses the kind that inspire them to take good care of their eyes?

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Senior
FOR MEN



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Division, in the number of subscriptions to Hygeia. (Duval County and the State Auxiliary are very proud of what Mrs. Harris has accomplished.)

Mrs. Henry Hanson read and explained her "Study Course on Medical and Health Laws of Florida." (This is a splendid piece of work done by Mrs. Hanson and sponsored by Mrs. J. Ralston Wells.)

The Duval Auxiliary voted at this meeting, against affiliation with the county Federation of Women's Clubs.

It was decided that the next meeting should be held in the home of one of the members.

ADVERTISERS' NOTES

Fifty-five years ago Colonel Eli Lilly opened a modest laboratory for the preparation of pharmaceuticals. It was located on an Indianapolis side street. The steady growth and development of the institution bearing his name reflects the ideals of the founder which in turn have been carried on by the only son, J. K. Lilly, now head of the corporation, and his two sons and their associates. Throughout their fifty-five years Eli Lilly and Company have been directed by men trained in pharmacy, medicine, and the related professions, men whose primary interests have been in the manufacture of products to be used under the direction of physicians.

Colonel Lilly's original laboratory has grown into a group of twenty-five major buildings covering several city blocks. Scores of departments are quartered here. The research and control staff alone numbers more than seventy-five persons among whom are chemists, physicians, bacteriologists, and pharmacologists. A corps of forty devote all their time to research problems. After fifty-five years the Lilly Laboratories may truly be said to be an index to the aspirations and purposes of the company which in keeping with the spirit of medical research which led to the development of such products as Iletin (Insulin, Lilly), Liver Extracts, Amytal, and Sodium Amytal confines its efforts to the medical field and seeks recognition for its products solely through professional channels.

Nearly 75 years ago, Dr. E. R. Squibb founded a modest pharmaceutical laboratory which was destined to become the modern institution of E. R. Squibb & Sons. Through each succeeding year the business has grown in size because it has grown in service

(Continued on page 46)

William D. Jones

Pharmacist

Laura and Adams Streets Jacksonville, Florida

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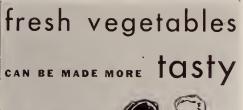
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Out-of-town Orders Shipped by Return Mail

HERE

is one of the advertisements of The Sugar Institute

THE advertisement reproduced here is one of the series appearing in newspapers throughout the country. In order to keep the statements in accord with modern medical practice, they have been submitted to and approved by some of the leading authorities in the field of human nutrition in the United States. The Sugar Institute, 129 Front Street, New York.





SEASONED WITH

As you make your selection of vegetables remember that their distinctive flavor can be

salt improves the flavor of sugar as salt to the French vegetables in a most pleasing dressing. The smooth, zestful way. It emphasizes the mild result will delight you. taste of spinach; mellows the tartness of tomatoes; blends of salt" is also a fine seasondeliciously with the flavor of ing for meat dishes, or soups peas, carrots, string beans, and stews composed of meat cabbage, asparagus, onions and other vegetables.

In serving raw vegetables Institute.

THE combination of sugar and in salads, add at least as much

"A dash of sugar to a pinch and vegetables. Flavor and season with sugar. The Sugar

Flavor and season with Sugar"



To improve lactation

—when nursing infants do not thrive

ACTUAL RESULTS conclusively prove that Cocomalt is an important factor in stimulating lactation. It increases the flow and improves the quality of milk. Because of its high caloric value Cocomalt amply meets the demands made upon the nursing mother's strength and energy by the drain of lactation. Cocomalt is of assistance not only when lactation is inadequate - but for growing children, convalescents, nervous, run-down men and women.

A perfect galactagogue quickly assimilated

Cocomalt provides all the necessary food elements for the production of milk. It contains Vitamins A, B Complex and D.

Mixed with milk, hot or cold, Cocomalt increases the caloric value of each glass 70%—adding 45% more protein, 48% more mineral salts, 184% more carbohydrates. It is easily digested, imposes no strain upon the digestion.

Available in 5 lb. cans for hospital use. Or at grocers and leading drug stores, in ½ lb. and 1 lb. sizes. Mail coupon for free trial can.



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R. B. DAVIS CO., Dept. AE-7 Hoboken, N. J. Please send me, without charge, a trial can of

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In the course of rapid progress new buildings, new methods, new discoveries have constantly supplanted the old.



One of the recent evidences of growth is the new Squibb Building at 745 Fifth Avenue, New York City. Here are installed the executive offices of E. R. Squibb & Sons, in an impressive setting that is in keeping with the modern architectural development of New York City and in harmony with the steady progress of the House of Squibb in the industrial world.

R. B. Davis Company says: "Cocomalt is not a malted milk, a chocolate mixture or a cocoa beverage. Cocomalt was perfected by prominent food experts in conjunction with a staff of instructors in one of our largest State Universities. It contains the nourishing elements of cocoa, eggs, barley malt, sugar, milk proteins and milk minerals. It comes in powder form, ready to be mixed with milk, hot or cold. So mixed, Cocomalt increases the food value of milk more than 70%. Every glass a child drinks is equal to almost two glasses of plain milk—yet it is so easily digested, so quickly assimilated, that even a delicate child can drink it five or six times a day! The extra proteins, minerals and carbohydrates thus supplied are highly valuable in building sound, strong, husky little bodies. Actual gains of from four to six pounds a month are reported regularly by mothers all over the country."

S. M. A., a product of the S. M. A. Corporation, is recognized by most physicians to be the nearest existing approximation of mother's milk. directions are given on the lav package. Moreover, each can bears this statement: "Use only on order and under supervision of a licensed physi-(Continued on page 48)

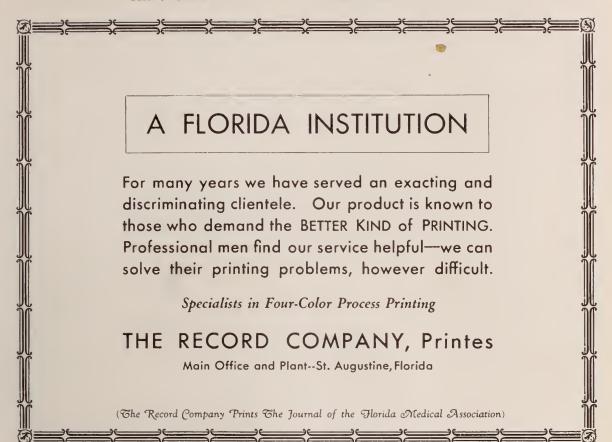


See Description, Journal A. M. A. Volume XLVII, Page 1488

A scientific combination of Bismuth Subcarbonate and Hydrate suspended in water.
Each fluidrachm contains 2½ grains of the combined salts in an extremely fine state of subdivision.
Medicinal Properties: Gastric Sedative, Antiseptic, Mild Astringent and Antacid.
Indications: In Gastro-Intestinal Diseases, Diarrhoea, Dysentery, Cholera-Infantum, etc. Also suitable for external use in cases of ulcers, etc.

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In using lactic acid milk for infant feeding, physicians find Mead's Powdered Non-curdling Lactic Acid Milk No. 1 (containing Dextri-Maltose) the simplest and most satisfactory medium for the preparation of lactic acid milk in the home or hospital. The proper amount of carbohydrate incorporated in this product correlates the lactic acid content, so that it is always ready for use. This product never curdles. Samples and literature sent on request. Mead Johnson & Company, Evansville, Ind., U.S.A.



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cian. He will give you instructions." It is advertised ethically to the medical profession only and sold exclusively through prescription pharmacies.

When physicians are confronted with undependable fresh milk supplies when feeding infants, especially in the summer time, it is well to consider the use of reliable powdered whole milk such as Mead's. Such milk is safe bacteriologically, of standard composition, is easily reliquefied, and is particularly desirable for the mother who takes her baby with her on her vacation. Under these conditions, Dextri-Maltose is the physician's carbohydrate of choice just as it is when fresh cow's milk is employed. The best method to follow is first to restore the powdered milk in the proportion of one ounce of milk to seven ounces of water, and then to proceed building up the formula as usual. Please send for our literature No. 61 which gives practical working formulae for modifying powdered and dried milks, evaporated milk, lactic acid milk, protein milk and cow's milk. Mead Johnson & Company, Evansville, Indiana, U. S. A.

Few drugs have attained greater prominence in a shorter period of time than Sodium Amytal, the sodium salt of iso-amyl ethyl barbituric acid, a product of the Lilly Research Laboratories. In a measure its quick adoption can be traced to the wide use of Tablets of Amytal, a Lilly hypnotic that has long rendered excellent service and proved particularly pleasing to physicians, because it leaves no undesirable after-results and produces sound, refreshing sleep.

The sodium salt of Amytal has a wide range of uses. In surgical patients it reduces preoperative anxiety. It lessens the quantity of inhalation anesthetic required, diminishes nausea and other objectionable post-operative features. The obstetrician notes relaxation of the perineal muscles and unusually rapid softening of the cervix following the oral administration of Sodium Amytal.

The physician in general practice finds Sodium Amytal effective either by mouth or by rectum for the production of mental and physical rest in acute and chronic ailments, for the control of convulsions, and, in conjunction with analgesics, for pain relief.

Pulvules Sodium Amytal, No. 222, are supplied through the drug trade. Literature is available on application to Eli Lilly & Company, Indianapolis. Indiana.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIR-CULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912,

of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIA-TION, INC., published monthly at Jacksonville, Florida, for April 1, 1931.

STATE OF FLORIDA, & ss. COUNTY OF DUVAL. &

Before me, a Notary Public, in and for the State and county aforesaid, personally appeared Shaler Richardson, M.D., who, having been duly sworn according to law, deposes and says that he is the editor of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of Publisher, Florida Medical Association, Inc. Post office address, Box 81, Jacksonville, Fla.

Editor, Shaler Richardson, M.D. Post office address, Box 81, Jacksonville, Fla.

Wanaging Editor. None.

Managing Editor. None. Business Manager, Stewart G. Thompson, D.P.H. Post office

address, Box \$1, Jacksonville, Fla.

2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Florida Medical Association, Inc. (A Corporation not for profit—no stockholders).

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security bolders, if any, contain

the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest, direct or indirect, in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is

(This information is required from

daily publications only.)

FLORIDA MEDICAL ASSOCIATION, INC.

By Shaler Richardson, Editor. Sworn to and subscribed before me this 27th day of March, 1931.

S. G. Thompson,

Notary Public State of Florida at Large (SEAL) (My commission expires April 9, 1932.)

Form 3526-Ed. 1924.

NOTE.-This statement must be made in duplicate and both NOTE.—This statement must be mode in duplicate and both copies delivered by the publisher to the postmaster, who shall send one copy to the Third Assistant Postmaster General (Division of Classification), Washington, D. C., and retain the other in the files of the post office. The publisher must publish a copy of this statement in the second issue printed next after its client. its filing.

> THE NEXT MEETING OF THE FLORIDA MEDICAL ASSOCIATION WILL BE HELD AT SARASOTA

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

SCH	EDULE OF MEETINGS—C	OMPONENT SOCIE	ETIES FLOR	IDA MEDICAL AS	SOCIATION	
COUNTY	SECRETARY	Date	MEI Time	ETINGS	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday		White House	Yes.	73%
Bay	D. M. Adams, M.D., Panama City.					100%
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		80%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Com-	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		71%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally.	50%
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	94%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Chamber of Com- merce Building	No.	77%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Beard of Health Building	No.	76%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	69%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	79%
Madison	Geo. O. Davis, M.D., Madison.					67%
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	64%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies .	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Court House	Yes.	88%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every other Friday	8:00 P.M.	500 Power & Light Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.		Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okesche- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
Washington- Holmes						

NOTE-Secretaries: Please submit information to complete the above schedule.



Statistics compiled by authorities in the field of alleray indicate that over 60 per cent of all Hay Fever cases are of the Fall type. Figures also show that over 90 per cent of Fall cases are of the ragweed type, and that this type is the most serious of the seasonal attacks.

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Meeting of the Florida Dermatological Association. 75

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Pinch salt Pinch cinnamon			••••		
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One ser	otal ving	27 4.5	34	33 5.5	546 91

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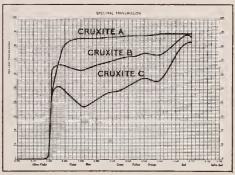


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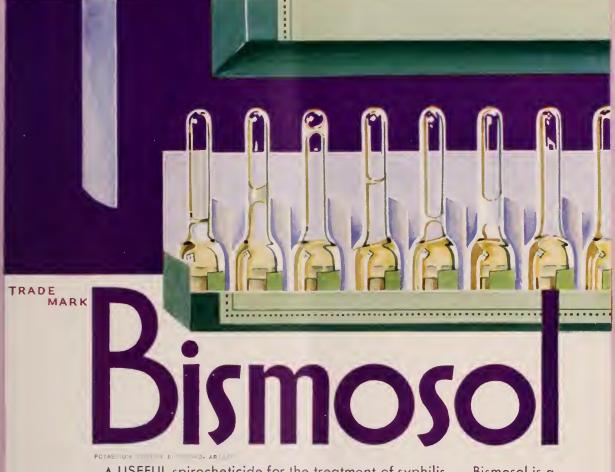
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PUBLISHED MONTHLY

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Number 2

A CLINICAL CONSIDERATION OF INTRAVENOUS UROGRAPHY*

Louis Orr, M.D.,

Orlando.

As early as 1905, shortly following the advent of instrumental pyelography, Volkner and Von Lichtenberg first began experiments to determine the possibility of producing a shadow of the urinary tract in the roentgenogram by intravenous injection. The results were not successful due to the toxicity of the materials used. In 1923, Rowntree, using large doses of sodium iodide intravenously, was the first to show that urography by the excretion method was possible, but not generally practical owing to the objectionable reactions of the drug manifested in certain patients. To Roseno goes full credit for attaining success in intravenous urography. By using a urea-iodide combination he was able to visualize the urinary tract to such an extent as to make a clinical interpretation in a series of cases. It was found, however, that the substance used was not universally tolerated and the method, clinically, not entirely successful.

It remained for Swick and Binz, working in the clinic of Professor Von Lichtenberg, of Berlin, to discover a compound which had been synthetized from the selectan group which fulfills all the requirements for clinical success. It produces an excellent urographic shadow, and has been proven to be non-toxic in the quantity necessary for intravenous injection. To this new substance the name Uroselectan has been given.

Before this preparation was presented to the general medical profession, it was placed in the hands of a representative group of American urologists for trial, the results of which were presented at the last meeting of the American Urological Association.

Intravenous urography opens a new field in urological diagnosis, and becomes a valuable adjunct to general diagnosis as a whole. It gives a method of outlining the urinary tract without the use of the cystoscope, and is apparently free from harmful reaction. Many practitioners of medi-

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

cine who have been opposed to examination of the urinary tract with a cystoscope will offer the injection method to the patient, and the roentgenologist will do the rest. As a result many fascinating diagnoses will be made, many pathological conditions overlooked, and others incorrectly interpreted. Injustices to the patient will surely result from improper urinary surgery performed solely on the basis of the roentgenogram without the other important considerations which can only be evaluated by the use of the eystoscope and ureteral catheter. To completely disregard the time-proven methods of accurate, urinary diagnosis is a matter of grave concern in the minds of those most closely associated with urinary tract diagnosis. It is to be hoped that the general profession will weigh most carefully the merits and demerits of this new method and appreciate its very definite limitations as well as its helpfulness in attempting to reach a clear understanding of the condition of the urinary system.

The genito-urinary surgeon must also be reminded of the danger of becoming careless and accepting the findings of a single roentgen film as a final basis for surgical intervention. That which is depicted by the roentgen-ray represents in only a small part the total amount of information necessary before an accurate conception of the true state of the urinary system can be gained. The evidence gained from intravenous urography will, in only rare instances, be sufficient and in these cases it will be where cystoscopy is impossible or dangerous. It is in these cases that the intravenous method will be distinctly advantageous and give information which could not otherwise be obtained.

Among the cases referred to are those of small children and infants in which cystoscopy would be difficult and perhaps hazardous, cases of tuberculosis of the bladder in which the ureteral orifices cannot be located, in exstrophy of the bladder, in those instances where a hypertrophied prostate makes impossible ureteral catheterization, and in cases where the ureters have been transplanted into the bowel. One of the most helpful ways in which intravenous urography has proven a definite aid in urinary diagnosis is illustrated in a

patient I recently examined with a cystoscope because of a complaint suggesting a lesion in the left urinary tract. The right ureter was catheterized the full distance without difficulty. The left catheter was arrested in the pelvic portion of the ureter. All attempts to inject a contrast medium up the ureter failed. A blocked ureter was quite naturally suspected, but an injection of uroselectan showed a normal pyeloureterogram.

Intravenous urography offers a means of securing bilateral pyelograms without the possibility of any untoward reaction which some claim does occur. It has been asserted by some authorities that uroselectan depicts a method of satisfactory functional determination of the kidneys in that the renal output can be measured by the intensity of the shadow cast in the roentgenogram, and by determination of the amount of the drug eliminated in the urine and the amount retained in the blood. The elimination and retention tests entail far too much laboratory procedure for practical use, but the visual interpretation of the kidney shadow offers a fair method of determining the renal output.

Investigators have shown that as renal function diminishes so does the output of uroselectan, and in the same ratio does the density of the urographic shadow decrease. It has likewise been shown that the density of the shadow is dependent also upon the degree of obstruction along the urinary tract in the nature of ureteral kinks, strictures or calculi. The more complete the block the more dense is the shadow. Consequently the more dense urographic shadows produced are those of the large hydronephroses which are caused by obstruction below. The problem of correct estimation of renal function in such an instance becomes most confusing, and oftentimes very misleading. In such a kidney the true function may be very low indeed with only a trace of indigocarmine found in the collected specimen after a considerable period of time, although the shadow produced by the intravenous method would indicate a greater degree of function. Kidneys in which all functioning parenchyma has been destroyed will produce no shadow whatsoever, but aside from this fact it is doubtful whether or not the functional value of this bears any relation to the degree of visualization.

In some cases of small intrapelvic renal calculi the comparative estimation of renal function is said to be more accurate than with the retrograde method. It is a well-known fact that many times a kidney pelvis will show signs of stasis and dilatation with but a small amount of indigo-carmine coming through the kidney, even though the stone be located in the tip of one of the calyces. Examination of the same kidney after the removal of the stone oftentimes shows a complete return to normal. This temporary suppression in function would seem to be due to the presence of the stone in the pelvis, and is only an apparent suppression as shown by the visual evidence produced by the intravenous method. It is my feeling that this finding is very misleading as the concentration of the dye is undoubtedly due to the stasis within the kidney pelvis.

It is not a very difficult task with the retrograde method to be able to obtain a fairly correct conception of the function of the kidney containing the stone by a careful study of the pyelogram, the size of the kidney in the roentgenogram, examination of the urine for infection, and a study of the divided function even though the affected side be partially suppressed. It seems much wiser to use the method we feel to be accurate in diagnosing renal calculi, and know more about the exact location of the stone, whether it be intra or extrarenal, than to know exactly the functional state of the kidney, if it is a positive fact that proselectan is secreted in normal amounts when phenosulphonephthalein or indigo-carmine is greatly suppressed, a condition which I do not feel exists.

The intravenous method is not satisfactory for interpretation where there is present glomerular or interstitial nephritis associated with surgical disease of the urinary tract, in that the nephritis alone causes sufficient diminution in function as to make the concentration of the dye inadequate for interpretation. In cases of tumor of the kidney, early tuberculosis and polycystic kidney, retrograde pyelography surpasses the intravenous method conclusively in that an insufficient amount of the dye is secreted into the kidney pelvis to render an accurate interpretation possible.

One must be particularly guarded in diagnosing suspected shadows in the region of the kidneys as urinary calculi by the intravenous method. Oftentimes shadows which have been shown to be intrarenal in the intravenous urogram will be proved to be extrarenal by retrograde pyelography. Likewise, shadows which the intravenous method has shown to be outside the kidney will occasionally be found later within the kidney. Retrograde pyelography should in every instance be employed in the diagnosis of renal calculi.

Uroselectan is of great value in the diagnosis of an impacted ureteral stone in that it will give valuable information as to the condition of the ureter above the obstruction, and the amount of damage present in the kidney which could not be otherwise obtained. Serial roentgenograms will give much valuable data relating to the dynamics of the ureter and kidney pelvis, and will bring to light many duplications of the ureter and pelvis which might be overlooked by the cystoscopic method.

Some observers have made the claim that intravenous urography will aid greatly in diagnosing ureteral stricture, and that the diagnosis can oftentimes be made with this method alone. This claim, I feel, is somewhat open to question, because of the very poor ureteral shadow produced in all ureters in which there is not very definite obstruction from one cause or another. It must be borne in mind that the average concentration of uroselectan in the urine of a normally secreting kidney is only 5%, which produces a shadow much less in density than does 12.5% sodium iodide. At best the diagnosis of ureteral stricture is oftentimes most difficult, and one which should be most guarded, even with the use of all the methods and means we have at our disposal. However, the intravenous ureterogram does depict as clear a conception of the true condition of the ureter as is possible with none of the changes which may be caused by the irritation of the ureteral catheter and sodium iodide in the retrograde method. Even though this be true the findings are often very confusing and areas which might be interpreted as definite narrowings and strictures are commonly found absent on the passage of the ureteral bulb or bougie.

While a great forward step has been taken in the progress of urinary diagnosis, and a very definite aid has been placed in the hands of the general surgeon. I feel very strongly that a word of warning should be sounded that the method should be one of corroboration, and should not entirely displace the proven methods so long in use. It should be regarded as a supplement to our present diagnostic procedures except in those instances where information would be otherwise unavailable.

DISCUSSION

Dr. E. S. Gilmer, Tampa:

I think Dr. Orr's paper is very timely and wish to commend him for bringing to our attention the limitations as well as the advanges of uroselectan in urological diagnosis. He has covered the subject quite well and there is not much to add. Uroselectan is undoubtedly one of the outstanding contributions to urological progress and ranks along with the X-ray, the cystoscope and the X-ray catheter as an aid in making urology an exact science. Dr. Orr and I attended the last meeting of the A. M. A. when the substance was presented to the Association as a finished product and enthusiasm ran high among most of those present. However, some of those who had had considerable experience with it had recognized some of its limitations and were more conservative. It certainly opens up opportunities in cases where instrumental pyelography is impossible or impractical; such as cases of impassable urethral stricture, some cases of urinary tuberculosis, where a ureter opens into a bladder diverticulum, cases where the ureters have been transplanted into the rectum and so forth. In these cases there is no other way of obtaining the desired information. However, cases like these are in the minority and I believe where practical, retrograde pyelography is of distinct advantage, since it offers a wide range of study of the genito-urinary tract not to be gained by intravenous urography. One of the disadvantages of intravenous uroselectan is that, as Dr. Orr has pointed out, it has a concentration of only 5% and it has been found that it takes a concentration of 15 to 20% to produce the opacity of 12½% sodium bromide, the usual opaque medium used in retrograde urography. Consequently there is a considerable loss of detail which fact makes it unreliable in many cases of beginning pathology when it is most urgent that an early diagnosis be made.

The liver and kidneys are principal points of elimination and simultaneous severe damage of these organs is one of the contraindications of its use. Another point I wish to emphasize that Dr. Orr brought out is that poor or no pictures at all are obtained in cases of marked glomerular damage with infection or destruction of the parenchyma. Obstructive condition resulting in damage to the tubules before there is much parenchymal damage give the best pictures.

The chief advantage of intravenous pyelography with the exception of cases where ordinary pyelograms are inadvisable is the checking of findings of instrumental pyelography, whereas heretofore it has been necessary to repeat pyelograms sometimes several times. It is an invaluable aid

in the study of the physiology of the genito-urinary tract.

Dr. Roy J. Holmes, Miami:

I am sure we have all enjoyed Dr. Orr's paper on this most timely subject. The author has very wisely strengthened his presentation throughout with just a touch of warning which I am sure has had its effect. Several months ago I was very much impressed by a discussion given by Dr. Keyes before a large gathering of urologists. Those of you who know Dr. Keyes know that he usually says the unexpected and that he has a very fine sense of humor. In his discussion he presented a series of cases and pointed out the pathology in detail as visualized after uroselectan. No one suspected that the actual pathology did not exist until he presented instrumental pyelograms of the same cases showing conclusively that the "pathology" had disappeared. Our experience with uroselectan has convinced us of its unquestionable value in those conditions which Dr. Orr has called our attention to as well as in those conditions where gross pathology is suspected. We are unhesitant in saving that in those obscure conditions such as beginning clubbing of the calyces from back pressure, the moth-eaten appearance of the calvees seen in renal tuberculosis, stricture of the ureter, and many others dear to the heart of every urologist, the method, at present, does not compare with instrumental urography. We must remember that uroselectan at its best gives us visualization of only that portion of the urinary tract which is in diastole and that that portion of the tract which happens to be in systolic contraction is visualized very poorly if at all. Another point which has not been brought out is the expense of the intravenous method. The cost of medical care is a subject which descrives every consideration at the present time. A fair estimate for intravenous pyelographic study in a hospital for one day is between forty and fifty dollars. Too often it becomes necessary to subject the patient to the additional expense of instrumental urography in order to complete the diagnosis which could have been made with the latter method alone. Intravenous urography if used and not abused is one of the most valuable additions to our present-day armamentarium and gives to urology a sense of security which enhances its well-deserved reputation for accuracy.

Dr. Robt. B. McIver, Jacksonville:

We are unwilling to operate on the upper urinary tract without cystoscopic and retrograde pyelographic studies additional to other diagnostic data.

In regard to children: The urinary tract of male infants and all children can now be studied cystoscopically. Observation instruments No. 10 F. and bilateral catheterizing and irrigating cystoscopes at No. 14 F, make the work very practical. This latter instrument accepts two No. 4 F. catheters, or one No. 6 F, catheter.

Dr. W. M. Shaw, Jacksonville:

I feel that a discussion on the X-ray side of this paper is in order.

Since uroselectan was introduced, a new preparation known as skiodan has been introduced. It can be mixed up and kept indefinitely without deteriorating, and it is just as non-toxic as uroselectan. Uroselectan has to be used very soon after it is prepared.

I think that one of Dr. Orr's best points was his last one, in that uroselectan furnishes us with the best retrograde medium we have ever found. It does no damage and produces a beautiful shadow. But I think we all realize that we will have to learn to interpret very faint shadows on the X-ray films in this type of work. We are accustomed to dense shadows after using sodium iodide, but we will have to get away from that with the use of skiodan and uroselectan.

Just a word about reactions which were not mentioned: They are not serious, but practically every patient will complain of a feeling of warmth and when the solution is introduced a little rapidly there is pain and discomfort along the vein up as far as the shoulder. The feeling of warmth passes off very shortly and is not serious.

It is remarkable how soon you can get the kidney pelvis with all of the calyces and ureter filled. We have obtained excellent shadows within five minutes after removing the needle from the arm. It is almost instantaneous the way this dye appears in the urinary tract. We always get good cystograms because it collects in the bladder. I think we are going to find more bladder lesions if we follow this method.

If you leave the patient on the table without emptying the bladder, your shadows will remain dense in the kidney and ureters. But if you let them leave the table and void, within five or ten minutes, you will lose your pyelogram. Your ureters disappear, which shows how rapidly the dye is eliminated.

I think these are the only points that I have to add. I enjoyed hearing Dr. Orr's paper.

Dr. Louis Orr, Orlando (concluding):

I feel that there is probably nothing more to be added. However, I wish to thank these gentlemen for their kind discussions.

POST-OPERATIVE INTESTINAL ILEUS* J. RALSTON WELLS, M.D.,

Daytona Beach.

The terms "ileus" and "intestinal obstruction" are synonymous, but are often used to designate different forms of obstruction. Ileus usually classifies pathological conditions of intestinal stasis due to the walls of the intestine, their blood or nerve supply, technically a dynamic, (paralytic or spastic) ileus. Intestinal obstruction is generally used to indicate a mechanical obstruction, an adynamic ileus.

Post-operative ileus deals with both forms, the most usual being the dynamic, or paralytic ileus. A post-operative ileus may occur immediately, or years after, an abdominal operation. The subject under discussion is to be limited to that form occurring within the first few post-operative days.

The differential diagnosis is usually not difficult. A mechanical obstruction may be immediate, or ensue, after a three or four-day norma! post-operative convalescence. Colicky abdominal pains occur rather suddenly; peristalsis is at first hyperactive, especially in the region of the localized pain; in a thin abdominal walled subject. visible peristalsis can be seen. Reflex vomiting of normal stomach contents is often immediate and rapidly becomes projectile in character. The patient is in evident distress, the expression and complaint indicates real pain. There is at first no evidence of toxemia due to the obstruction. There may be one or two fair results to rectal enemas, but only the contents which might be residual in the lower bowel. Distention is rapid in onset. If the obstruction is partial or very low in the intestinal tract, the above chain of symptoms may be modified, and as the completeness advances, the symptoms advance apace. If the condition is not relieved, the pain and peristalsis may subside and a paralytic ileus complicates the picture.

In paralytic ileus, we have usually a "sick" patient with abdominal distress, but no real localizing pain. Peristalsis is at first evident in small amount at various points, becoming less until after twenty-four hours, more or less, a quiet abdomen is found. Unless the ileus is high, vomiting is at first only that which might be expected after a general anesthetic has been used. Vomiting consists of the usual sequence, a fecal type may take two or three days for its appearance, more and more projectile in character as the content becomes more foul. The feces becomes typical and show the apparent lack of water, despite measures used to combat dehydration. Abdominal distention is moderate, but persistently progressive until an extreme degree of tenseness may be reached. Our blood chemistry and blood picture alters progressively, a hypochloremia and a hyperazotemia are found; a raise in leucocytes may be expected. The late mechanical ileus and a paralytic ileus may blend, or combine, into the same picture and the actual existence of both forms may be present. The respirations are more rapid and shallow, the pulse rate mounts progressively and becomes thready in character, the temperature is usually almost normal unless peritonitis or some form of inflammation is present. A mounting temperature is generally a terminal indication. The temperature, pulse and respiration may be influenced by a concurrent condition such as peritonitis, pneumonia, or a draining abscess. The urine is increasingly scanty and contains little or no sodium chloride.

The surgeon should never neglect the digtalrectal examination, the use of the stethoscope, and the X-ray. In almost all of the one or twoday post-operative abdomens, if I listen with a mild degree of expectancy, I can readily hear transmitted heart sounds through the abdomen, especially in the epigastrium. The difference in conductivity is more prominent with increased abdominal distention. This sign is often quoted as a symptom but I do not regard it as especially diagnostic. Mechanical tinkle as often described is, when heard, a rare and late sign and should be classed as one of the "signs of lost opportunity" (Handley). When possible an X-ray examination, without opaque media, will, when properly interpreted, give extremely valuable diagnostic and indicative information. For best results, the examination must be with the patient in an upright position. The differentiation between air and

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

fluid distended bowel contrasted to the collapsed and normal, is often striking.

The etiology of adynamic ileus, or mechanical obstruction, is not usually obscure. Those most frequently met may be from crowding of distended intestines into an abdomen with formation of a kink or kinks; returning intestines to the abdomen with a loop twisted on its mesentery; an obstructing tumor in the lower sigmoid or rectum overlooked at operation which may have been performed for another condition. An acute kink of intestine around a drainage tube, or a fresh, rapidly formed band caused by or in the region of a drain uniting two limbs of intestine may be a cause. A possible, but unusual, form is a loop caught under a pregnant uterus.

Some months ago, I operated upon a young woman, five months pregnant, a physician's daughter, for an acute catarrhal appendix. Kidnevs showed albumen and casts present. Spinal anesthesia was used. No perforation had occurred but pus was contained in the appendiceal lumen. The operation was performed in a normal manner and the abdomen closed without drain. The patient was extremely restless immediately after operation, tossing from one side to another. Constipation and gaseous distention, accompanied by nausea, had been part of the history throughout the pregnancy thus far, so a continuation for the first two post-operative days was not alarming. Temperature and pulse subsided to normal. On the third day, the physician-father became alarmed, and I freely admit that I was not. The fourth day the vomitus changed its character, renal output diminished and the patient rapidly showed signs of dehydration and intestinal obstruction, despite the usual post-operative saline and glucose enteroclysis. Throughout the time since operation, some enemas would return with excellent results, and others returned clear, not even accompanied by flatus. At the end of the fourth day, we decided to reoperate. An enema just prior to the operation returned with a large amount of flatus and fecal material. Operation was postponed. The next morning the condition was again alarming and operation proceeded. A loop of lower ileum was found in the true pelvis behind the large pregnant uterus. Pressure marks were seen where the uterus had pressed on it against the sharp pelvic brim. The obstruction was relieved but due to the lateness of the operation, and the combined toxic condition, due to the obstruction, the kidney and the toxemia of pregnancy, the patient died several hours after the second operation. How or when the strangulated loop passed into the pelvis, I do not know.

No matter how unusual a condition may be, we should bear in mind the various mechanical etiological possibilities.

In paralytic ileus, the etiology is not so plain. It is, to my mind, distinctly of a nerve condition origin, a combination of sympathetic, parasympathetic or vagus nerve control. I do not think that when using normal, good surgical technique the so-called rough or gentle handling of the intestines is a very important factor. A ruptured viscus, with or without bacterial invasion, intraabdominal infection, or inflammation; intra or extra abdominal traumatism, will all produce ileus. Inflammation of the pancreas or gall-bladder, liver abscess or diverticulitis are known possible factors. Intense nerve shock, fear, etc., will by itself temporarily cause cessation of peristalsis and "bloating."

A localized appendiceal abscess, colon pus, placed in one of the usual positions, using normal operative technique, will give an excellent prognosis, but let the abscess contain streptococcus, or be placed near or on the mesentery, the prognosis alters due to a probable increased amount of ileus that is or will be present because of the infection of the mesentery, including its nerves.

The sudden relief of intra-abdominal pressure as after a Cæsarian section or after the removal of a large fibroid or cyst or after the operative relief of a mechanical obstruction, will often produce paralytic ileus. There is ample evidence (Markovitz and Campbell, Bayless and Starling) that the condition is one produced by faulty nerve supply. Sampson Handley has shown that one or more loops of bowel affected by bacteria become paralyzed locally, and by progressive stages advances, with a mechanical ileus above the paralyzed area. Cope's report bears this out well. This is undoubtedly true but the paralytic ileus per se is caused by over-stimulation or irritation of the nerve supply either by the nerve trunks per se, or their terminal filaments in the intestinal wall.

Theoretically and practically, all operations of opening the abdomen, using general anesthesia, give us a transient paralytic ileus. Call it nerve or traumatic, if you like, or rough handling of the viscera, it exists. Practically and clinically, its frequency has been variously computed, and like all statistics of this kind, is very misleading. If

we include the cases of peritonitis and abscess, ruptured viscus and severe external trauma, or mechanical obstruction occurring before operation, the incidence is high, up to 27%. If these known causes are eliminated, the incidence is as low as 2%. These averages differ in various authors' findings. The incidence is, however, so prominent in surgery, that the rigid care of prevention is one of the absolute demands on an abdominal surgeon.

The treatment is generally universal in basic measures, and my object is to stress several of the newer and more promising ones. Enema of all kinds, large or small, hot abdominal applications, gastric lavage, or reoperation are all essential at times. Drugs are of only passing importance, drastic purgatives in the absence of peristalsis are as bad as a laxative in a pre-operative appendicitis; they probably make the condition worse. Eserine and strychnine grains 1/80 and 1/40 by hypodermic, repeated every hour for four doses (Shoemaker) or pituitrin 1/2 ampule, surgical, by hypodermic, every hour for four doses (Lillianthal) have given me favorable results at times. Atropine is decidedly contraindicated in any dosage. Morphine will not only quiet the patient, but often lessens tension, and I believe promotes peristalsis in this condition under discussion. The best treatment is to prevent the severe sequence of events. If we believe that all post-operative abdomens have a transient paralytic ileus; that glucose is a food and a diuretic; that sodium chloride is essential; that water is a necessity; use the repeated, small, hot, rectal installations of not over six ounces of a 5% glucose and 5% saline solution every three hours. The constant Murphy drip is annoving to the patient. is often expelled, and the amount absorbed is not readily recorded. I have found that the early administration of hot water or hot tea by mouth is far less likely to promote distention than is ice or ice water. Therefore, hot water or hot tea, and hot rectal glucose and salt should be routine to prevent the possible severe type of paralytic ileus.

When ileus is diagnosed, the mechanical should be immediately operated, corrected and closed with or without an ileostomy. When in doubt, operate.

A paralytic ileus, in my experience, is entirely different. Early operation does no good, except to confirm diagnosis. The ileostomy far more often fails than succeeds; a second and a third have to be done at times, especially in cases of bowel

wall infection. The operation of ileostomy may be slight but is an added shock and usually drains only a small coil of gut. A high jejunostomy is usually a more formal procedure in order that you may be sure of intestinal localization, and more often relieves the upper bowel and gastric condition, but I do not think any more effectively than a small constant nasal tube with a Reyfuss bucket and the stomach flushed through this every several hours.

Two of the newer treatments based on theory. laboratory findings, and practice, are of exceptional promise, namely, the hypertonic saline and spinal anesthesia. 40 cc. of a 20% sodium chloride solution given intravenously, being repeated in four to six hours, as necessary, at times gives rapid and striking results. Along with this, it is well to use 1000 cc. of saline and glucose under the skin. Peristalsis may be heard in half an hour after the first dose, and a large foul-smelling stool result. Spinal anesthesia seems a heroic measure and one that we ordinarily would hesitate in doing with so severely ill a subject. Practically the blood pressure range is the only essential to observe. A very low systolic, 90 mm. or under, is a contraindication unless the blood pressure can be raised by ephedrine or other means. To be of use the anesthesia must reach approximately up to the level of the roots of the eighth intercostal nerves. The various reports are encouraging, and in a short time this may be an established procedure. One case that I remember responded with a large b.m. in four minutes. Whether using anhydrous cocains (Wells), stovaine or novocaine, the drug is of little importance except the last two must be guarded from going too high and producing uncomfortable or alarming symptoms of their own. The effect is to block the inhibito motor nerve fibers and allow normal peristaltic waves and muscular tone from the intrinsic enervation to become re-established. Spinal anesthesia should be done in the patient's bed and provision made for immediate bowel action, the emptying of the fecal contents sometimes being very copious and expulsive.

The use of perfringens antitoxin has not shown promise in my hands.

Like cancer surgery, or in fact any branch of medical science, the earlier the diagnosis can be and is made, the more promising the outcome.

Obstruction, without immediate operative measures preceding, should be operated upon at the first suspicion. In post-operative ileus, signs are difficult of interpretation. The complicating factors of pre-existing toxemia and general anesthesia serve at times to throw a very confusing complex on the problem. All signs and all laboratory aids should be rapidly called into use, and a decision reached. The results of this decision should be carried out promptly, thoroughly, fearlessly ,and without hesitation. The chances are against your patient, but they are worse the longer you take to decide and the more vacillatory your treatment. One of the greatest hindrances to radical treatment in immediate post-operative ileus is fear of public opinion. This fear should have no part in any normal surgeon's decision or action although a consultation is always advisable. Where peritonitis is present and the organism known to be streptococcus, paralytic ileus is complicated by a severe grade of toxemia. though measures to combat the ileus are more or less successful, the severe infection of the bowel wall makes a toxic condition of the general system that may not be overcome, and death from streptococcic toxemia ensues, the ileus being then only a minor factor. True paralytic ileus mortality is now over 60%, but let us hope that our newer findings, both in diagnosis and in treatment, will greatly alter this in the next few years.

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DISCUSSION

Dr. W .M. Rowlett, Tampa:

It has been a great pleasure to hear Dr. Wells' paper, and a happy privilege to me to be able to discuss it. He is dealing with a subject that is extremely interesting to those who are doing abdominal surgery.

While post-operative intestinal ileus may be rare, the high mortality resulting therefrom makes it one of the most serious complications that the surgeon has to deal with. Thus, everything possible should be done to keep him mindful of the possibilities of its occurrence. With such in mind, he is bound to be more cautious with his operations. Operative prophylaxis is the best prevention that I know of. In every abdominal operation, following an inflammatory process, or a previous operation, a most diligent, but painstaking search should be made for knuckles and adhesions of the intestines and omental rents. If found, they should be remedied. Success in dealing with the situation, after the ileus has occurred, depends upon our ability to detect early symptoms, making a correct diagnosis, and immediate surgery after being sure of our diagnosis. The roentgenogram offers us our best diagnostic procedure.

An over solicitous surgeon might mistake a severe attack of tympanities, with aggravated symptoms, with an ileus. However, when we find our patient with intense abdominal pain, evidence of shock, vomiting fecal material, and we are unable to get a bowel movement or the passage of flatus, it's time to suspect an obstruction.

There have been many remedies recommended to relieve these symptoms, such as eserine, pituitrin, morphine, etc. However, in my severe attacks of tympanities and vomiting, to help the patient to expel the gas and to restore the downward peristaltic wave, I have gotten excellent results with gastric lavage pituitrin, turpentine stupes, and high soap suds turpentine enemata. If there is much pain and restlessless, I believe barbital has an advantage over morphine.

A high intestinal obstruction is more serious than the lower type, on account of greater shock and increase in dehydration. In desperately ill cases I believe an enterotomy to relieve temporarily the condition, and later on go in and correct your pathology, is an advisable procedure.

Dr. J. Ralston Wells, Daytona Beach (concluding):

The general condition of the patient along with the physique of the patient and history has a great deal to do, I think, with the diagnosis of intestinal obstruction—what kind it is, where it is, and whether we should or should not operate.

CASE REPORTS: MALIGNANCIES OF THE TRANSVERSE COLON AND THE SIGMOID COLON

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Orlando.

Malignancy is, perhaps, the problem most urgent in its demands for solution at the hands of the medical and surgical world. While malignancy of the large bowel may not show so rapid a tendency to metastasis and may not be so rapidly toxic as in some other organs, this margin of safety is limited to some extent by the danger of intestinal obstruction, a complication which is usually the first cause of symptoms sufficiently severe to attract the patient's attention.

Nevertheless, surgery is able to effect a certain proportion of cures and in other instances can give grateful relief from distressing symptoms, and prolongation of life under more bearable conditions.

Malignancy of the bowel almost invariably means carcinoma and carcinoma of the large intestine is usually of the annular type. It is a malignant stricture of the bowel and while it is a neoplastic growth, it may not necessarily produce an enlargement, sometimes the diseased portion being actually smaller than the rest of the organ. From without, the growth may give the appearance of a groove or constriction, as though the bowel had been tied around with tape. longitudinal section shows that all the coats of the bowel have been drawn in. On the inner surface there is usually ulceration and necrosis. As the constriction tightens there is increasing difficulty in the passage of fecal contents and a consequent hypertrophy of the muscular wall of the intestine which is followed by a dilatation above the constriction. When the serosa has been sufficiently inflamed adhesions are formed to the surrounding structures, such as the omentum, coils of intestine. or the abdominal wall, and in this way a palpable tumor may be formed. These changes are largely seen above the obstruction. Sometimes intussusception of the malignant portion into the bowel below may occur.

While toxicity and metastasis are slow to develop in carcinoma of the colon, early diagnosis is of especial importance; because of the fact that when intestinal obstruction does appear it usually marks the final stage of the disease. Unfortunately it not infrequently happens that an acute intestinal obstruction gives the patient the first warning that he is the victim of a serious disorder. As a rule, however, the obstruction comes on more gradually and therefore gives the diagnostician an opportunity to study the condition and to arrive at some reliable conclusion based upon the observations made.

Pain is not ordinarily a symptom of great importance. It is colicky in character and is probably always caused by an obstruction. It may be

persistent enough to induce the patient to seek the physician's aid rather early in the disease and if the X-ray, sigmoidoscope, and other means of diagnosis are then employed, the condition may be discovered comparatively early. As a rule there is only discomfort at first, a feeling of fullness and flatulence often following some indiscretion in diet. Gradually the pain becomes more violent, but it is likely to subside and recur at irregular intervals, being relieved only when the bowels are freely evacuated.

Vomiting may not accompany these paroxysms of pain at first, but sooner or later it will appear and is likely to subside and recur, as does the pain, depending of course upon the degree of stenosis. When the stenosis becomes complete the vomiting becomes more continuous, although hours may go between the attacks even in the presence of a complete obstruction. Fecal vomiting will surely appear unless surgical methods prevent it.

Visible and palpable peristalsis is a valuable sign in this ailment. Exaggerated peristalsis is always present in intestinal obstruction, but in the case of a slowly developing obstruction of the lower bowel it becomes especially evident because of the hypertrophy of the muscular coat of the bowel above the constriction and also because of the emaciation of so many of these patients and the thinness of their abdominal walls. When the stricture is permeable only one or two coils may be involved, but when the obstruction is more nearly complete the whole bowel may be in spasm and form coils that are both visible and palpable.

A tumor mass may be palpated in a fair number of instances, but if it be in the hepatic or splenic flexures it often cannot be felt, and even in other parts of the colon it may be elusive because of the motility of the gut and tumor. The size of the tumor varies greatly because it is made up of adjacent structures which have become adherent to the growth, and it is also influenced by the amount of dilatation immediately above the growth.

Alternating attacks of diarrhea and constipation are frequently encountered during the gradual constriction of the large intestine, this being more common when the sigmoid or rectum are involved. The appearance of pus and blood in the stools is not at all common, but is very significant when present, and it too is more frequent when the disease is near the anal region.

Cachexia is slow of development but rapid emaciation follows marked constriction and ste-



PLATE 1. Taken November 30, 1926, showing passage of barium enema up through descending colon to middle half of transverse colon where obstruction is found.

nosis. One of our most valuable means of diagnosis is the X-ray, but at the same time discretion in its employment must always be observed. It is quite evident that time cannot be taken for an elaborate examination when the patient is suffering the agonies of an obstruction, but if the condition of the patient permits, an opaque enema and the X-ray may definitely locate the lesion.

When the variation in signs and symptoms of a chronic intestinal obstruction is taken into consideration, the difficulty of diagnosis of some of the cases of malignancy becomes evident. Exploratory operation will not infrequently be the only method of a complete diagnosis both as to the nature of the lesion and its location, and since operation offers the only possible relief to these patients the earlier it is done the more hopeful the outlook.

The operative management of these cases obviously cannot be made to follow any established routine. So many of the patients come to the surgeon suffering from complete obstruction that radical removal of the lesion at once is impossible —the patient could not survive such a procedure. The search must not be prolonged and the utmost gentleness must be exercised in handling an intestine made fragile by distention and infection. A hurried enterostomy of the most accessible loop of distended gut may often be the best procedure to follow, a colostomy fairly near to the growth probably giving the best immediate chance to the patient under these circumstances. Of course the ideal method of dealing with the disease is resection and anastomosis of the gut at the primary operation and this may be done when the condition of the intestine and the resistance of the patient are sufficiently favorable. Not only is primary resection the most favorable as to the comfort of the patient and time consumed in recovery, but it is the most favorable as to permanent cure.

Case 1.—Mr. N., age 48 years, first seen November 24, 1926. Gave history of having lost twenty pounds in weight in past eight months. Marked constipation, loss of appetite and general weakness. There was a palpable mass in the right side of the abdomen extending from the region of the appendix upward toward the epigastrium. The mass was about the size of a small grapefruit and by palpation it could be determined that the mass was inside the abdominal cavity. There was no history of passing blood by stool and until the week previous there was no vomiting of food, although great distress followed eating and he had

been on a diet of light soups and fruit juices to prevent the flatulence. A diagnosis of chronic appendiceal abcess involving the omentum was made and laporotomy advised. The patient was sent to the hospital on November 26th and the following findings were obtained. Weight 92 pounds, red blood count, 3,900,000, hb. estimation 60, white blood count 9,000 with 80% polymorphomiclear cells. Wassermann negative. Temperature 98 3/5, pulse 68, respiration 16, blood pressure 120 systolic 80 diastolic. A barium enema was given and under the fluroscope the barium was seen to fill the large bowel to the point where the mass was palpable. Then it filled out in a large round filling. On December 1st he was given a direct transfusion of 450 ec. of blood and on December 4th was given another transfusion of 350 cc. of blood. On December 6th he was operated upon under combination novocaine, gasoxygen-ether. A long right rectus incision was made over the mass. On entering the abdomen the mass was found to be due to an intussusception of the tranverse colon to which the omentum had adhered. It was impossible to relieve the intussusception so the mass was removed in its entirety. The mesentery of the colon was removed along with fourteen inches of the colon. (Measurement made after removal and the intussusception dissected out.) An end to end anastomosis of the transverse colon was made with triple layer of black silk. Two drainage tubes were put in place and the abdomen closed in usual manner. patient made an ideal convalescence with the bowels moving for the first time five days postoperative. Two subsequent transfusions were given on December 19th and December 28th of 350 cc. each. On January 10th he was given a barium enema and fluroscoped. The union of the transverse colon was normal and the enemata filled normally to the ileocecal valve. Sections of the cauliflower-like tumor mass found in the intussusception were removed and sent to Atlanta for examination and the pathologist's report is as follows: Gross Study: Small sections of the tissue very easy to cut and a fish flesh color. No areas of necrosis. Microscopic examination: Sections of the tissue show an epithelial growth with very little connective tissue stroma. The epithelial cells are arranged in gland-like structure. There is marked inflammatory change throughout all the sections with cellular infiltration and destruction of the epithelial growth. Near the edge of some of the section there is more connective tissue



PLATE 2. Taken January 10, 1927, showing filling of transverse colon by barium enema. Picture taken 34 days post-operative. A-B indicates section of colon removed.



PLATE 3. Twenty-four-hour plate taken August 2, 1927. Notice filling of entire transverse colon.

and all of the sections show infiltration of the epithelial growth. Diagnosis: Adeno-carcinoma.

The accompanying X-ray plates show the results obtained in this case. This man is now traveling on the road in the state of Kentucky and was last seen in the summer of 1930. He weighs over 140 pounds and his bowels move regularly daily. Apparently there has been no recurrence to date. He has a small ventral hernia where the drainage tubes were in place, but the hernia causes him no inconvenience.

Case 2.—Mrs. W., age 41 years. First seen November 12, 1930, when she came in for prenatal care. Multiparae, this being her sixth pregnancy. Three miscarriages all under four months, cause unknown. Two living children 18 and 12 years, respectively. Last menstruation May 30, 1930. This patient was a high school principal and desired to carry on her work as long as possible. On her first examination, weight 127 pounds, blood pressure 110 systolic 80 diastolic. Urine negative. Measurements normal. Wassermann negative.

The patient was seen again November 27th, and blood pressure was 114 systolic 80 diastolic. Weight 130½ pounds. Urine alkaline and otherwise negative. Bowels normal by taking a combination of magnesia-oil half ounce to ounce daily.

Patient not seen again until January 10th. Urine alkaline, specific gravity 1.032, weight 132 pounds. Blood pressure 112 systolic 80 diastolic. Patient explained that as she lived in rural district and was getting along nicely did not see necessity in coming in for bi-monthly examination. Bowels moving regularly.

Patient next seen February 23rd, weight 133½ pounds. Condition same as previous examinations. No complaints.

Patient not seen again until March 10, 1931, when she delivered a full term baby boy after six hours in labor. No tears, normal delivery. Patient seen daily for ten days post-partum and ran an ideal post-partum convalescence. Patient got up on 14th day and began regular domestic duties.

On April 1st husband called by office and said that his wife's bowels had been sluggish for two or three days and wanted advice on her condition. Soapsud and glycerine enema daily with morning dose of salts advised. April 4th, bowels had not moved for four days. Gastric lavage with soda glucose solution and one-half pint of concentrated Epsom salts solution left in the stomach. Patient retained salts about an hour and vomited. No

results. Sent to hospital on April 4th. Rectal examination revealed no impaction. High colonics of soda and glucose gave no results other than a little gas. Patient beginning to have hiccoughs and vomiting a little clear fluid when taken. Diagnosis of intestinal obstruction made and advised laporotomy. There being no palpable mass in the abdomen it was thought that probably coils of the intestine had been strangulated by omental adhesion to midline scar of operation for removal of right cystic ovary and tube fourteen years ago. Operation refused. Medical consultation called in. Despite the fact that bowels had not moved for over a week the patient was apparently not toxic. Abdomen was slightly distended and marked peristaltic waves could be seen and felt. Some pain was complained of in the supra pubic region over the midline sear. Efforts to get an elimination failed despite the use of turpentine stupes, enema, eserine, paristaltine, and cathartics by mouth. Diagnosis of intestinal obstruction confirmed by medical consultant and laporotomy advised. Patient was given 1000 cc. hypodermoclysis of 3% glucose q 8 hours for four thousand ec. Temperature 99, pulse 110, respiration 18, white blood count 8,600 with 76% polymorphonuclear. At 8:00 p. m. April 7th, spinocain was given in an attempt to relieve obstruction. Glycerine, salts, and soapsuds enema given at 8:30 was expelled with no results. At 7:00 p. m. April 8th spinocain was again given and laporotomy performed. On opening the abdomen the entire transverse colon from the ileocecal valve to the sigmoid was found to be greatly distended. In the middle of the sigmoid there was found an annular constriction giving the appearance of being tied tightly with a tape, the bowel below the constriction being normal in appearance. There were no adhesions to the affected area of the sigmoid. There was no glandular enlargement in the mesentery and the section was removed from the sigmoid with the cautery knife. An end-to-end anastomosis of the cut ends of the sigmoid was made and the abdomen closed with drains in place. The patient made a good convalescence and bowels moved twice on April 14th, six days post-operative, eliminating a soft liquid copious stool, gas being eliminated freely by rectum previous to that time after operation. Bowels moved on the morning of April 15th normally, and at 2 o'clock on the same afternoon. At 3 o'clock in the afternoon, one hour after the last bowel movement, while the patient was apparently



PLATE 4. Twenty-four-hour plate before evacuation. Taken August 4, 1927.



PLATE 5. Picture taken immediately after evacuation. Note emptying of colon. Picture taken August 4, 1927.

comfortable and lying in bed reading, she was seized with a sudden, sharp, staggering pain in the epigastrium and immediately went into shock. Her temperature dropped to 96 by rectum, pulse 140, and respirations 26. She was covered with perspiration and cold and clammy. Diagnosis of mesenteric emboli was made and patient treated for shock. She never rallied and died 2:00 a.m., eleven hours after she was first seized with the epigastric pain. Autopsy was not permitted.

Following is the report of the pathologist on the specimen removed: Gross study: A large tumor mass from the lower sigmoid, section of the growth shows a moderate inflammatory reaction and destruction of the tissue. There is marked contraction of the lumen of the sigmoid. Microscopic examination: Sections of the tissue show a large amount of destruction throughout all sections. There is an epithelial growth with the formation of gland-like structure. Areas of the section show marked necrosis. A study of the character of the cells indicate a highly malignant growth. Diagnosis: Adeno-carcinoma of the sigmoid.

This last case to the writer is a very interesting one. It shows the insiduous onset of a carcinoma of the large intestine. This patient, before she became pregnant, was, according to her husband, more or less constipated and it was necessary to take laxatives. He considered her like almost all women whom he said he understood were more or less constipated. She did not present the cachectic state nor the anemia found in malignancy. During her pregnancy, with her dietary restriction and magnesia preparations she had no trouble with her elimination. She went through a full term to a normal delivery. Her bowels moved normally for nearly two weeks postpartum. There was never any history of hemorrhoids nor the passage of blood or mucous from the stools and up to the time she was operated upon she never had any fecal vomiting or bile vomiting. She merely vomited fluids or food taken by mouth until they were discontinued. She was in good condition for the operation and good condition post-operative until she got her mesenteric embolus.

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MEETING OF THE FLORIDA DERMATO-LOGICAL ASSOCIATION

A short business meeting of the Florida Dermatological Association was held at Jacksonville on June 14, presided over by Dr. J. L. Kirby-Smith of Jacksonville as chairman. Rules of eligibility for membership were discussed, also the publication of proceedings. It was decided that the members from each district should be allowed to invite guests to the meetings when held in their district.

After the business meeting the following cases were presented for discussion:

Case No. 1.—Varicose Ulcer (Presented by Dr. J. L. Kirby-Smith)

T. S., colored, aged 45, stevedore. Duration, eleven months, location, left leg. Leg was injured one year ago by a fall of a piece of lumber. A large indolent ulcer resulted which showed no signs of healing until nine days ago when strapping was begun. Since that time healthy granulations have appeared and the ulcer is healing rapidly.

No discussion.

Case No. 2. (Presented by Dr. J. F. Wilson)

Diagnosis: Mrs. L. S. S., white, female, housewife, aged 26. Location, upper lip, duration six weeks. Round scaly patch of dermatitis, five by six centimeters which almost disappears at times only to return somewhat larger. No treatment has been instituted except soothing ointments.

DISCUSSION

Dr. Andrews: It is a keratotic spot that must be watched.

Dr. Saxton: It is a keratosis possibly pre-cancerous. I would treat it with X-ray.

Case No. 3.—Epithelioma, Lower Lip. (Presented by Dr. J. L. Kirby-Smith)

Leukoplakia, lower lip, used iodine. Growth began eight months ago. No glands felt. Heavy smoker. Size of lesion, 1 by ¼ inches. Transverse area of leukoplakia central part circumscribed infiltrated area rather superficial. Treated with eleven milligrams of radium filtered with a half millimeter of aluminum, two hours, to growth. Leukoplakia treated twenty minutes. Same amount radium unfiltered. Four E. D. X-ray filtered with 5 mm. aluminum to spot and to both sides of neck.

DISCUSSION

Dr. French: I have seen a number of similar cases, a large number of wart-like growths appear in dirty mouths. Can not determine if cancerous without biopsy. More apt to be mycotic than bacterial. I instruct patients with this condition to have thorough dental care. I believe this growth to be verucca and not an epithelioma. They appear only in men and are often multiple. There is usually no further trouble after X-ray treatment. The bacterial infection accounts for the glandular enlargement.

Case No. 4.—Leukemia Cutis (Presented by Dr. J. L. Kirby-Smith)

Mr. C. B., white, aged 53. Began with a general itching eruption and gradual lymphatic enlargement two and one-half years ago. Cervical, inguinal and axillary glands greatly enlarged. General pruritis with excoriations. Laboratory findings, negative, except for blood study which showed 14,200 white blood corpuscles, polyneut, 58, lympho, 38 and many anemic red cells. Treated by weekly doses of neoarsphenamine and one-third skin units of X-ray filtered over glands.

DISCUSSION

Dr. Kirby-Smith: Hopeless case but can keep trouble down for several years with treatment used at present. The blood report was of no importance. Will dissect one of the glands.

Dr. Andrews: It is of the lymph blastoma type. I advise laboratory diagnosis by biopsy.

Dr. Saxton: I agree. I would have blood count repeated and would continue with X-ray.

Case No. 5.—Seborrheic Eczema (Presented by Dr. J. L. Kirby-Smith)

C. M., white, female, aged 18. Has had several outbreaks of seborrheic eczema since childhood, usually on face and scalp. Menstruation irregular. No disturbances of digestion. Location, scalp, face and chest. Heavy crusted condition of scalp. Treatment, X-ray, ultra-violet ray, vaccines, autohemic injections, alkalies and tonics.

DISCUSSION

Dr. French: I would put her on an extremely low carbohydrate diet. Have a stomach analysis in view of hydrochloric acid content secretion. The significant thing is amenorrhea. Ten days before the next period inject an ampoule of thecin in the buttocks every other day. The local treatment is variable.

Dr. Andrews: I agree that the suggestions of Dr. French are very good. This type of eczema is hard to handle. Starch poultice, and salicylic acid to soften scalp.

Dr. Saxton: I would use 5% oleate of mercury and lime water for local treatment.

CASE No. 6.

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Mr. H., male, white, aged 25 years. Present illness began six or seven months ago. Uses tobacco considerably. No venereal history. The base of the tongue and roof of the mouth contain white rough plaques. Lesions in buccal cavity have an appearance of lichen planus. Treatment, by perborate of soda. Gave prompt results.

DISCUSSION

Dr. Andrews: I think the patient was practically well until he quit treatment. Now only 90% well. Laboratory examination. I agree with Dr. Kirby-Smith, the only way to prove anything is by laboratory examinations.

CASE No. 7.

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Mr. G., white, male, 33 years of age. This case presented at previous clinics, also reported to State Medical Association.

DISCUSSION

Dr. French: I think there is no reason to call it tuberculosis except granuloma. No symptoms or anything significant in slides to indicate diagnosis. I think you should be satisfied with progress. Call it granuloma. Etiology unknown.

Dr. Saxton: I would use ionization copper electrode.

Case No. 8.—Papular Urticaria. (Presented by Dr. J. F. Wilson)

R. B. C., white, male, aged 2 years. For past six months has developed papula lesions over face, forearms and legs, pinhead to pea size. Treatment, diet, calcium by mouth and ultraviolet ray. Apparently benefited at times. But condition promptly returns.

DISCUSSION

Dr. Andrews: I think it is lichen urticatus. I would use mild lotions, rhubarb and soda or milk of magnesia.

Dr. Saxton: HCL internally.

Case No. 9.

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Mrs. S., white female, age 42. Two years ago there gradually appeared a number of small pearly growths around sebaceous glands of both cheeks. No subjective symptoms. Description, circumscribed pearly papules around sebaceous glands, about thirty-five in number. About 1 mm. in diameter. Treatment, galvanic cautery.

DISCUSSION

Dr. French: Think of the fact that it is over the area where she uses most grease and cosmetics. Unable to make a diagnosis. Vaselineoderma. Relation of cosmetics to disease.

Dr. Saxton: Biopsy would determine diagnosis. Hypertrophy dermal or subdermal. Treatment is evidently effective.

Case No. 10.—Epithelioma Lip. (Presented by Dr. J. L. Kirby-Smith)

M. K., white, male, 35 years of age. White plaque on lower lip for past four years. Two new growths have gradually appeared. Smoker, Teeth bad. Location, lower lip. Lip lesions of indurated character, one-half to three-fourths inches in diameter, probably of basal cell type. Sublingual glands palpable. Treatment, curetted under local anesthesia, then cauterized. Eight E. D. unfiltered X-ray units were applied. Eleven num. of radium with 2 mm. brass filter were applied for four hours.

Case No. 11.—Leukoplakia and Epithelioma. (Presented by Dr. J. L. Kirby-Smith)

J. F. L., white, male, aged 61. Began about one year ago as a white spot on the lip, at times it appears to increase in size. Pipe smoker. Location, left half of lower lip. Circumscribed areas one-fourth and one-half inch in diameter, of slightly infiltrated mucus membrane, whitish in appearance. Larger one has the appearance of an epithelioma. No discomfort or roughness. No treatment as yet.

DISCUSSION OF CASES 10 AND 11

Dr. French does not consider Mr. L. F. the same as No. 3 and No. 10. He has excessively dry skin, keratotic warts on back of hands, and seborrhea of the scalp. His lip is more pre-cancerous in nature than No. 10 and No. 3.

Dr. Kirby-Smith: There is an angioma and a small patch of leukoplakia. Suggests heavily filtered radium treatment.

Dr. Andrews said X-ray is just as good. Watch him.

Dr. French would use unfiltered radium.

Case No. 12.—Seborrheic Eczema, (Presented by J. L. Kirby-Smith)

J. M. P., white, male, aged 46. Duration, five months. Has been treated for syphilis. Has a scaly, itchy place on penis. Distribution is on the penis, hands and feet.

Description: Dry, slightly scaly, brownish itchy plaque on penis. Feet and hands yellowish keratosis; between the toes there is maceration. Inguinal glands enlarged. Treatment: Four E. D. X-ray to penis weekly, boric acid ointment, five per cent H. A. ointment, sulphur ointment and Witfield's ointment.

DISCUSSION

Dr. Kirby-Smith: Is it gonorrheal keratosis? Dr. Andrews: Dermatophytosis-secondary dermatitis genitals.

Dr. French: Lichen planus. Predominantly papular. Significant lesion on the forearm. Obviously the patient is not generally well. Profuse perspiration. More like lichen planus than mycotic infection. Few lesions in the mouth.

Dr. Andrews: Mild treatment. No stimulating treatment.

Dr. French: Arsphenamine oftentimes produces lichen planus eruption. Overtreated.

Case No. 13.

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Miss M., white, female, aged 24. Deep-seated vesicles have been reoccurring in crops on hands and feet for several years.

DISCUSSION

Dr. French: Dr. Hopkins, New York City, last meeting of the American Medical Association, discussed the bearing of Monilian infection of gastro-intestinal tract, causes skin infection due to Monilia. Appearance, interdigital, would suggest (can't get proper laboratory diagnosis) that you pay some attention to the gastro-intestinal tract. In this case, benefit derived from acidophilous, low carbohydrate diet, or high protein diet.

Dr. Saxton: Nails are rough, suggestive of nail infection. Epidermophytids.

Dr. Kirby-Smith: The more I see, these are the kinds of cases by which we make our reputation and cure our patient. Soon the whole field of dermatology can be straightened out, in the next few years, as to the origin of these cases. Dermatophytides-ring worm fungus. Clear-cut case.

Case No. 14

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Mrs. B., white, female, aged 38. Three years ago developed a soft bleeding tumor, size of a bean in a birth-mark. Treatment with electrolysis for the past two and one-half years. Four other angiomas have appeared at different times. Description: Elevated smooth red nodule in the area of the birth-mark, scars of previous lesions and two more possible beginning angiomas. Present treatment, procaine, galvanic cautery, radium and X-ray. The question is between simple angioma and angiosarcoma.

DISCUSSION

Dr. Saxton: Removal of latest lesion for microscopic study. Removal with actual cautery or with knife.

Dr. Andrews: Classification correct. Suggests electric coagulation. No more X-ray.

Dr. Saxton: Remove whole area.

Case No. 15 (Presented by Dr. J. F. Wilson)

Diagnosis: A. W., white, female, aged 27. Maculo papular eruption in plaques and some scattered lesions. Some pigmentation, in individual lesions, some regular in outline, some circinate. Began six weeks ago and is confined to the exposed parts of the body. Has had no treatment.

DISCUSSION

Dr. Kirby-Smith: Multiform erythema. Eruption cleared up 75% in three days.

Dr. French and Dr. Andrews did not see any pigmentation.

Case No. 16

(Presented by Dr. J. L. Kirby-Smith)

Diagnosis: Mrs. S., white, female, aged 64. Began four and one-half months ago as a somewhat sharply defined erythmatous area left side of upper lip. Mucus membrane is eroded. The area around the lesion is indurated for one-half an inch. She is nervous, somewhat anemic and has cancer fear, cervical glands palpable. Laboratory tests are negative. Had previously had six doses of X-ray in four weeks' time.

Present treatment: Mixed infection vaccine and boric acid ointment.

DISCUSSION

Dr. French: Treated four and a half months with local applications (X-ray, vaccines, neoarsphenamine). Lip indurated edema, probably syphilis. Dark field can be expected to be negative at this time. Spirochetes deep down in the lymphatic stream. Four months is too late for dark field. Eruption not diagnostic but suggestive of syphilis.

Dr. Andrews: Dr. French's statement is pertinent in this case. If syphilis we should be able to prove it.

Dr. Andrews wants X-ray treatments figured out.

CASE No. 17.—Scabies

(Presented by Dr. J. L. Kirby-Smith)

N. D., white, male, aged 5 months. Has papular eruption on palms, soles, face and trunk, with some vesiculations. Case presented to show lesions of scabies on the face which is unusual and seldom if ever seen in an adult.

THE FIFTY-NINTH ANNUAL MEETING

of the

Florida Medical Association

will be held at

SARASOTA

EDITORIALS 79

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Elsewhere in this issue, you will find a report of the activities of our Public Relations Committee. You will recall that at the state convention held in Orlando this last May, the House of Delegates accepted the report of the Executive Committee and voted to make the Public Relations Committee a standing committee, auxiliary to the Executive Committee. The members are to serve for five years, the term of one or more expiring each year, with the President filling the vacancies as they occur by appointment. At the same time

you may recall the secretary pro-tem of this committee made a report of the preliminary activities which showed that progress had been made in quite a definite way, in regard to the procedure to be followed and the grouping, into special sections, of the work which should be undertaken.

This committee has for its aim the educating of the general public regarding scientific medicine and the part the medical profession has played in advancing it, thus making this old world of ours a safer place in which to live.

We feel that this new activity will be of outstanding value to the man in medicine, as it will endeavor to, and will, interpret for our public the physician himself, giving a picture not of the man they know rushing from bedside to bedside; harassed by urgent and ofttimes needlessly insistent calls, with lids heavy with sleep and mind saturated in sadness; a friend dying next door and possibly a child sick at home; with efforts in behalf of the neighborhood misunderstood;—but, a picture of his zeal, enthusiasm, energy, self-sacrifice, with a thirst for knowledge that will fit him for greater services; with dreams of relief for suffering and of promoting happiness through health.

It will also instruct our public regarding facts in medicine in a positive and convincing manner, as contrasted with the fads and fallacies which arise from day to day flourish for an hour, but to fade and disappear.

This work has already been started in several sections of the United States with gratifying results. The public seems to be desirous of knowing the why and wherefore in medicine, as well as in theology or mathematics and probably more so. There may be some difference of opinion as to type and extent of this education and also as to the methods employed, but these angles will be smoothed off as the program swings into the race for conservation of human life and the spreading of knowledge and medical truths.

To put this plan over successfully will take of one's time and thought. This work will be hard on members of the committee but the results will be so far-reaching that every member of the Florida Medical Association should be willing to cooperate, to give freely of his talents and ability to help out in this program, which is, we believe, as important today as anything else undertaken by the state organization. We believe its effect will be successful in curbing the rapid advance of state medicine and communistic ideas regarding medicine and will also lessen the influence of

various cults on our gullible easily influenced public.

We trust we are wrong when we state that we believe one of the many difficulties, if not the greatest, in putting this program over will be the disinclination of many men to undertake work of this nature, which takes of one's time and thought. It will undoubtedly put some burdensome detail upon those willing ones, who volunteer to help, but the service will be for the good of medicine in the whole state, a part of which each doctor is; hence, one will be but helping himself in assisting others. To prove we are in error and we trust you will do so, it will be necessary for every one who is approached to accept willingly the burden offered and enthusiastically carry on, doing even more than is asked. This is an altruistic work with no returns to the worker other than comes to him through the general good, which will extend to all members of the medical profession. The cause is a good one and may the responses to the committee's appeal be

"One hundred hands flung up reply One hundred voices answered I."

CORRESPONDENCE

From Dr. John S. Helms, Tampa, July 21, 1931:

I am pleased to add a few suggestions to the correspondence that has appeared recently in the editorial columns of the Journal upon the subject of a "President-elect."

Primarily my reaction to this matter is that the Constitution and By-Laws of our State Association have become very largely obsolete and do not fit in entirely with the requirements of a present-day medical organization.

I am not unmindful of the adaptability, appropriateness and usefulness of the Constitution and By-Laws as originally drafted and adopted, and I yield to no man as to my reverence of its antiquity, but all things must pass and it is hoary with age and has not kept pace with modern medical progress.

I am in favor of some plan whereby the Association may choose a "President-elect" one year before he is to become president. The benefits to the association in the matter of increased efficiency of the incoming president are obvious. In this connection, I may state that I am not in favor of any custom whereby it is understood that the vice-president from time to time shall be elected president, regardless of his fitness for the honor and its duties.

In order that it be possible to create such an

office as president-elect and provide for his annual election, it would be necessary to pass an amendment to the Constitution and By-Laws.

Since this question has arisen, and since it seems necessary that there be something done about it, I would suggest that the present president of the association immediately appoint an interim emergency committee to be charged with the following duties, viz.:

I. To carefully study the present Constitution and By-Laws.

II. To suggest such amendment, or amendments, as may be necessary to meet the present needs and near future needs that may be anticipated, including an amendment providing for the creation of the office of "President-elect", manner of his election and defining his duties, or

III. To rewrite the Constitution and By-Laws entirely providing for items above outlined.

IV. To write the amendments or a new Constitution and By-Laws as above outlined in due form and cause same to be published in the Journal at least three months before the next meeting of the Association as provided for by the Constitution and By-Laws to be voted upon for adoption or rejection, or amendment, as the case may be, at the next regular meeting of the Association.

I have no available copy of the Constitution and By-Laws but from memory I believe this plan to be in accordance with its provisions.

(Signed) JOHN S. HELMS.

From Dr. Leigh F. Robinson, Ft. Lauderdale, July 7, 1931:

I was very much interested in your editorial entitled "Shall We Have a President-Elect?" and want to go on record at once as being in favor of the affirmative side of the question. The plan is one that is being adopted by all kinds of organizations because it has been found to have worked out well by the organizations that have adopted it. The principle is sound as it gives the newly elected President one year to become conversant and familiar with the office. I do not believe that interest in the elections would be lessened if the plan were adopted.

I have discussed the idea with a large number of members at different times and I am of the belief that over 90% of the membership is in favor of a president-elect. Therefore I think that if the matter is brought before the house of delegates it will easily receive the required two-thirds vote.

(Signed) LEIGH F. ROBINSON.

From Dr. Bundy Allen, Tampa:

Inasmuch as the House of Delegates of the American Medical Association and the question and the correspondence in the June issue of the Florida Medical Journal are so closely dovetailed, it seems appropriate to make mention of them at this time. Quoting in part from page 595: "The House of Delegates is a very important component of the Association. It has the power to change or amend our Constitution or By-Laws. It elects our representatives to the American Medical Association and is in general the legislative and business body of our Association. It frequently happens that the individual members of this body are called upon to vote on matters which have been brought to their attention only a few moments before. Under such circumstances, careful consideration and thoughtful study of the problem is, to say the least, extremely difficult."

Therefore, this is a matter for serious thought and consideration for the future welfare of the organization. This is important for the reason that there are continually coming before the body vital topics for discussion and disposition.

Consequently each and every county society should carefully select the Delegates to represent its respective group. Too frequently the Delegate is elected but may or may not attend the State meeting and in either case is uninstructed.

The county society presidents should always meet with their Delegates, instruct and impress upon them the obligation they have accepted and the importance of faithful attendance in the sessions. The State Delegates so selected and instructed would naturally use the same precautions in selecting a representative to the House of Delegates of the American Medical Association.

The State Medical Associations should by all means reimburse the Delegate for the expense encountered while attending the annual sessions of the American House of Delegates. Therefore, I wish to take this opportunity of recommending or suggesting through these columns, the following changes, which I believe will be of material value to the Association as a whole, as well as the individuals in the medical profession:

1. That the Constitution be changed to read: Article VII of the Constitution, Section 1, be amended to read:

"The Officers of this Association are to be a President, President-elect, first, second and third Vice-Presidents, a Secretary and Treasurer, Editor of the Journal, Executive Committee and the proportioned number of Counselors."

- 2. That all resolutions to be presented to the House of Delegates shall be typed and furnished to the Editor of the Journal in time for publication before the meeting is called to order.
- 3. That the actual expense incurred by the Delegate while attending the American Medical Association be paid to the Delegate by the State Association.
- 4. That the Sarasota and subsequent Programs be arranged as follows:
 - (a) The customary Roentgenological meeting and the Florida Railway Surgeons, Monday, followed by the usual informal Smoker in the evening.
 - (b) The principal Scientific Session shall convene Tuesday morning at 9 a. m. and continue through the day, followed by the annual banquet in the evening.
 - (c) The Scientific Session shall be resumed Wednesday morning and continue until 12 o'clock noon, at which time the Officers of the Association shall be elected and the annual Session adjourn.

The election of a President-elect for the Florida Association is very essential and will materially improve the Sessions and management of the Association for reasons too numerous to mention. But there is one thing that warrants the change; that is the opportunity afforded the President-elect of studying the affairs of the Association for one year in close association with the President, and as ex-officio member of all committees.

The precedent of electing the Vice-President to the presidency is entirely wrong and in no way is comparable to a President-elect. Therefore, the nomination and election of a President-elect carries with it the same dignity and interesting features that have been experienced in the past in electing the President—which in reality is electing the President.

The resolutions should be printed for the reason stated in your correspondence that "it frequently happens that the individual members of this body are called upon to vote on matters which have only been brought to their attention a few moments before."

The members of the State Association are "imposing on good nature" when they elect a delegate who will conscientiously attend the Ses-

sions of the House of Delegates of the American Medical Association, necessarily personally sacrificing much of the general program for the good of the State Association—and at his own expense.

The annual program, if conducted as outlined above, would furnish an audience for the last man on the Scientific Program, to which he is justly entitled, whereas in the past the Officers have been elected at noon and immediately following the election the majority of the members depart for their homes before the program is completed.

Therefore, the above plan would allow ample time to complete the Scientific Program with an incentive for the membership to remain in Session for the election and installation of the officers.

(Signed) BUNDY ALLEN, M.D.

From Dr. John E. Boyd, Jacksonville:

"Memorial for Physicians Who Served and Died in the World War."

This is the heading employed by the American Medical Association Bulletin to urge state organizations, county societies, hospital staffs, professional clinics and individual physicians throughout the United States to subscribe to a fund of ten thousand dollars with which to pay for furnishing and decorating a salon in the new million-dollar building, "Pershing Hall", which is now nearing completion in the City of Paris, and in which it is planned to preserve in sculpture, painting and historical mementoes, a record of America's participation in the World War.

I cannot, somehow, console myself to the idea that the cost of erecting such a memorial, which is to adorn the metropolis of France, should be met with funds obtained from the American pocketbook. It seems to me, in fact, that if France truly desires to show her gratitude to the United States by erecting a building that will reflect a befitting honor upon those Americans who died in defense of French soil, French homes, and French lives, that the funds needed for that purpose would be secured altogether from the French people. Moreover, I feel no hesitancy in suggesting the fitness of the French people erecting such a building in this country and locating it in our capital city. It is a known fact that France, today, is one of the two wealthiest countries in the whole world, so that the financing of such an undertaking should not prove to be a hardship.

I could not help but wonder, while reading this article, how the camouflage which is being made

use of to further this financial drive, is going to react on the American doctor who plowed through the mud and the shell holes over there, lay down to sleep whenever and wherever he could, and marched all night, for many nights, with only mud under foot and rain overhead.

A shaft could not reach too high towards the sky, nor could a building cost too great a sum, if either of them were intended to commemorate what the American soldier accomplished during the World War. I feel confident of a concurrence in that opinion by civilized people all over the world. But what zephyrs shall fan the sides of such a shaft, or what soil shall furnish the foundation for the building would surely bestir many differences of opinion. The American soldier I encountered along the line of battle front would not. I am sure, vote to erect a memorium where it would be kissed eternally by French zephyrs, and forever rest in sight of the river Seine.

It is admitted that the appeal which is employed to further the interest of this campaign possesses the strength of a colossus, and the sentiment which surrounds the unborn babe. Those that served in the thick of the fight over there will donate to almost any fund designed to enhance the glory of the men who sacrificed their lives in order that others might live. American gold might erect to their memory a sacred and gem-studded mosque in the land of the Nile; it might uprear to their everlasting glory a mighty shaft of onyx in the midst of Africa's darkest jungle; it might dedicate to their gallant sacrifice a monumental tomb of the rarest jade and rest it upon the bank of the majestic Thames; it might honor their undving devotion by constructing a temple of sterling silver somewhere in the Far East, or actually consecrate our capitol itself to their unselfish patriotism and vet produce only a ripple on the surface which covers depths that are so easily stirred by the merest vibration of memory's chords.

If a memorial building is to be paid for by the American people, I would yearn to have its foundation laid on American soil in close proximity to the little gray stones that dot the surface of Arlington, and have its mighty flagstaff reach towards an American sky, while the stars and stripes waved in the breezes that come from off the bosom of the historical Delaware.

The real American is not going to evade this appeal. He will give, and give cheerfully to anything that will honor or glorify those men they enshrouded so tenderly, each in his own blanket, and then laid them away beneath the sod with due reverence and great sadness. No publicity expert had to be employed in any campaign to evolve a propaganda that would stir the souls of those men who had been left behind and no artist was required to camouflage the leading purpose of the picture. Almost every man, woman and child in these United States understands the appeal that is enshrouded in the name of "Pershing", and you may be sure that every last one of its citizens is keenly alive to the "all powerful" urge stimulated by reference to the unknown soldier who gave his all in the fight for democracy.

(Signed) John E. Boyd.

PROCEEDINGS OF THE TWELFTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION Orlando, Florida, May 11, 1931.

The general session called to order by J. S. McEwan, M.D., of Orlando, local surgeon of the Atlantic Coast Line, chairman of the local committee on arrangements.

Invocation: Dean Melville Johnson, St. Luke's Cathedral.

Address of welcome on behalf of the local surgeons: Calvin D. Christ, M.D., Orlando, local surgeon of the Seaboard Airline Railway.

Address of welcome on behalf of the city of Orlando: Honorable James L. Giles, Mayor.

Response to addresses of welcome: L. M. Anderson, M.D., Lake City.

President's Address: "Our Medico-Legal Status," Gaston H. Edwards, M.D., Orlando.

SCIENTIFIC PROGRAM

Address (by invitation), "Opportunities and Responsibilities of the Railroad Surgeon," Southgate Leigh, Chief Surgeon, Virginia Ry., Norfolk, Va.

"General Aspect of Head Injuries and Spinal Injury Cases," Ralph N. Greene, Jacksonville. Method of handling the patient. Value of X-ray examination. The aspects of spinal puncture. The surgical interference.

"Infections in Traumatic Surgery," R. O. Lvell, Miami.

"Physiotherapy in the Treatment of Traumatisms," H. M. Strickland, Live Oak.

'Sacro-Iliac Pain from the Standpoint of the Railway Surgeon," C. C. Webb, Pensacola. Few

symptoms of injury are as frequently brought to us by sincere and insincere railroad workers as sacro-iliac strain. Therefore, the anatomy, symptomatology, clinical examination, diagnosis and treatment are considered.

> General Session, May 11, 5 p. m.

Secretary-Treasurer's report, by Dr. E. W. Warren, showed collections of only seventy-seven dollars out of a membership of two hundred and four in good standing. This condition has prevailed for two preceding years. The costs per annum of operation is approximately one hundred dollars. The treasurer had paid the deficits of the two preceding years himself. After considerable discussion of the matter, most of those present paid one and two years' dues, two members paying three years' back dues, which resulted in a sufficient income this year to pay operating expenses.

The following officers were then elected: President, Thomas H. Bates, Lake City; vice-president, Geo. C. Tillman, Gainesville; secretary-treasurer, E. W. Warren, Palatka (held over).

The new president was escorted to the rostrum and assumed his office. The retiring president, Dr. Edwards, presented the association with a beautifully carved gavel for its future use, which was accepted in the name of the association by Dr. Bates.

The following resolutions were then adopted:

RESOLUTION

Whereas, the Orange County Medical Society and the City of Orlando are joint hosts to the Florida Railway Surgeons' Association on the occasion of its twelfth annual meeting, and

Whereas, the members of the association and their guests have been warmly received and every possible courtesy shown them, and

Whereas, the natural beauty of the city of Orlando and the inherent hospitable nature of its citizens enhance the enjoyment of our visit, therefore

Be it resolved, That the Florida Railway Surgeons' Association go on record as felicitating and thanking the Orange County Medical Society and the city of Orlando for being perfect hosts, and

Be it further resolved, That a copy of this resolution be sent to the Orange County Medical Society, one to the city of Orlando and one kept in

the minutes of the Florida Railway Surgeons' Association.

C. W. SHACKELFORD, Chairman; C. C. WEBB, H. D. CLARKE,

Committee.

RESOLUTION

WHEREAS, Doctor Southgate Leigh, Chief Surgeon of the Virginia Railway, is honor guest of the Florida Railway Surgeons' Association at its twelfth annual meeting, and

Whereas, the acceptance of our invitation has entailed the loss of much valuable time from his arduous duties, and

Whereas, his essay, "Opportunities and Responsibilities of the Railroad Surgeon," contributed so much to the success of the Scientific Program, and the thoughts conveyed will prove an incentive, and improve the efficiency of every railroad surgeon who heard him, therefore

Be it resolved, That Doctor Leigh be extended a vote of sincere thanks by the Florida Railway Surgeons' Association and a copy of this resolution be sent to Southgate Leigh and one to the President of the Virginia Railway.

> C. W. SHACKELFORD, Chairman; C. C. Webb, H. D. Clarke,

> > Committee.

A discussion then followed in reference to certain points raised by the visiting speaker, Dr. Leigh, in reference to foreign transportation which was interesting and encouraging. It was brought out by Dr. Leigh that most of the railroads have come to recognize the value of their surgical departments, and are realizing more and more that anything that advances the ability of their surgical staff gives added protection to not only the railroads but to their patrons, also.

This principle was apparently first given real thought and attention by the railroad administration under Mr. W. G. McAdoo during the World War. This has been recognized by the American Railway Association and as a result they have in nearly every instance agreed to furnish foreign transportation to surgeons who are visiting clinical meetings of various associations, of state medical organizations, conventions, etc., that tend to increase the efficiency of the surgeons.

A few roads yet look on their surgical staff as z sort of necessary nuisance and afford them as few courtesies as possible. In some cases the

very contracts offered their surgeons to sign and the fee and rate sheets that accompany these contracts are a most insolent in the language in which they are couched.

Great and good work has been done since the World War by a band of chief surgeons headed by the late Dr. Dounott, but obviously more work is necessary before the executive departments of all the roads are made to realize the value of their medical and surgical departments.

Possibly the smallest of our services to railroads is that of looking after those injured in line of duty, in wrecks and crashes. We have rendered most valuable service in addressing the management on sanitary drinking cups, sanitary toilets on trains and at stations, proper sewage disposal, proper drainage of station grounds, mosquito prevention, etc.

We find our advice being sought more and more as the years lapse and both the roads and their patrons and employees are the beneficiaries. The matter of proper ventilation of railway passenger and sleeping cars and sterilization of bed linen has been improved by proper adherence to advice of medical and sanitary units of the companies concerned.

The matter of improved refrigeration of freight and sanitary supervision of the culinary departments of dining cars and station restaurants have been improved by capable advice of their medical departments.

In the face of all that, we are bound to feel that the value of our services are poorly recognized. A look at the fee schedules indicates how our services impress executive departments. Notwithstanding that each road has a chief surgeon. who is usually an outstanding member of our profession, he in so many instances instead of maintaining his loyalty to his profession, standing up and fighting for the rights of his staff as the head of every other department in the employment of the particular road, will turn right around and acquiesce in arrangements that would makehis blood boil were it a case in which he was not personally interested and afraid to open his mouth in protest. It can't be that he is so glad to get the place and so afraid to speak on behalf of his colleagues when the time comes to make fees and terms for his staff, trembling in his boots with fear that he might offend and thus lose the coveted place. It is more likely that he finds it such a herculean task to convince executives, who have grown in the idea and acquiescence in the beaten

path, that he has to use all the diplomacy at his command and work slowly, waiting for the inevitable changes in management and executive heads who are more amenable to modern realizations of what their medical staffs can be worth to them if properly utilized, remunerated and respected.

Think of the chief surgeon who will tremblingly agree to an agreement that allows him to wire a local surgeon at a certain point, a busy man whose time is worth money, to jump in his automobile and drive a distance of thirty-five miles to assist the local surgeon there with a case of fracture of the skull, fracture of right arm, dislocation of left arm, fracture of right thigh and left leg and dislocated ankle, bring the patient back to the hospital and look after him till he dies, a matter of forty-eight hours. His contract allows him \$2.00 for the first two miles and ten cents a mile one way for the other 33 miles. When in the hospital, he is allowed to charge a fee of \$1.50 a visit which will include dressings, casts, etc., for all those desperate wounds. It is probably suggested to him that one visit a day ought to suffice. Finally, when the patient dies, he should render a bill for \$8.00 or \$10.00 and be eight to ten weeks in getting a voucher for that meager fee. When a claim case is to be tried in a distant city, this same surgeon is called to be there, leaving his practice, and he must stay almost a week at the munificent fee of \$15.00 a day and expenses at a suggested moderately priced hotel. The surgeon selects a good hotel and pays the difference in

The following committees have been appointed to serve for the ensuing year:

EXECUTIVE

C. W. Shackelford, M.D., Chairman, West Palm Beach.

N. A. Baltzell, M.D., Marianna.

C. M. Tvre, M.D., Eustis.

SCIENTIFIC

J. M. Irwin, M.D., Chairman, St. Augustine.

J. Brown Farrior, M.D., Tampa.

T. M. Rivers, M.D., Kissimmee.

NECROLOGY

C. C. Webb, M.D., Chairman, Pensacola.

L. M. Anderson. M.D., Lake City.

H. D. Clark, M.D., Ft. Pierce.

ARRANGEMENTS

Joe. Halton, M.D., Sarasota, together with all other railway surgeons in the county who are members in good standing.

MEETING OF PUBLIC RELATIONS COMMITTEE

A meeting was held on July 5th at 1:45 p. m., Hotel Marion, Ocala, of the Public Relations Committee, component part of the Executive Committee of the Florida Medical Association. President G. H. Edwards, chairman of the Executive Committee, Gerry R. Holden, and business manager, Stewart G. Thompson, met with the committee.

Those answering roll call were H. C. Dozier, chairman; J. M. Irwin, J. S. McEwan, Homer L. Pearson, J. A. Simmons and J. Ralston Wells.

For reorganization purposes and for the consideration of several points that directly concern the President and the Executive Committee, Dr. Dozier requested Dr. Edwards to call this meeting.

Dr. Edwards briefly told the committee what he expected to accomplish, and stated that he and the Executive Committee would aid in any way possible. Both Dr. Edwards and Dr. Dozier expressed hopes that the organization of various units would be completed and ready to operate effectively by the first of October.

Dr. Edwards called attention to the approval and acceptance of the report of the Executive Committee at Orlando which includes the proposition of a rotating membership of this Public Relations Committee. New members when added would be appointed by the President upon recommendation by the Committee.

Dr. Holden proposed that the work of the Committee apparently was so great that a direct Committee member should be appointed from the regional areas of Florida in such a way that the entire state would be covered. By unanimous consent the Committee was, therefore, increased from the original number of six, as recommended by the Executive Committee of 1930, to ten members, and this Committee was recommended to be made a standing Auxiliary Committee.

Dr. Edwards proposed that Dr. Dozier and Dr. Wells be appointed for a term of five years and four years respectively. The other eight members of the committee, by mutual consent, were appointed to serve in rotating terms. The completed list, therefore, reads:

Dozier, Ocala, and Irwin, St. Augustine, 5 years. Milam, Jacksonville, and Wells, Daytona Beach, 4 years.

McEwan, Orlando, and Palmer, Tallahassee, 3 years.

Pearson, Miami, and Simmons, Arcadia, 2 years. Smith, Tampa, and Payne, Pensacola, 1 year.

President Edwards retired from the chair and Chairman Dozier started the business of the committee.

Dr. Simmons made a motion, seconded by Dr. Pearson, that the present chairman and secretary, as elected by the old committee and approved by President Edwards, serve for the year 1931-1932, and that hereafter the committee will appoint its own officers from year to year. Carried.

Dr. Dozier introduced the subject matter of the Committee's work which is to consist of the original sections, namely. Speakers' Bureau, Radio Bureau, Motion Picture Bureau and the Press Bureau. Dr. Dozier went at length into the subject of the Radio programs. One complete series of radio talks would deal with medicine in general, would number twelve talks to be given one each month, using the following subjects:

- (1) Some Interesting Medical History in Florida—Edw. Jelks.
- (2) The Florida Medical Association; What It Is and the Value of Its Influence to the State—Gerry R. Holden.
- (3) The Medical Profession—G. H. Edwards.
- (4) The Medical Profession—Its Contributions to Charity in the State of Florida— Ralph N. Greene.
- (5) The Medical Profession—Its Economic Contributions to the State of Florida— H. C. Dozier.
- (6) The Medical Profession—Its Value to Society—M. A. Lischkoff.
- (7) What Surgery Has Contributed to Society—Roy J. Holmes.
- (8) What Internal Medicine Has Contributed to Society—Robt. M. Harris.
- (9) The Value of a Hospital to a Community—Robt. B. McIver.
- (10) What is a Class A Hospital—Its Security to the Patient and Its Value to the Doctor? —J. Ralston Wells.
- (11) The Florida State Hospital Association— Its Aims and Aspirations for the Good of the Public—John A. Bowman.
- (12) The State Board of Health (subject to be named)—Henry Hanson.

Another radio section would be broadcast from four local stations once every two weeks on medical subjects. For example:

(1) General, which would include health examinations, vaccine, diet, exercise, etc.

- (2) Specialties, such as Ear, Eye, Nose and Throat.
- (3) X-ray.
- (4) Pediatrics, and on through medicine and surgery.

The Speakers' Bureau would furnish to the medical societies topics to bring before the public; would furnish an already made talk which could be altered by each speaker according to his own ideas and general usage of the subject; would also furnish speakers to local societies when requested and also speakers and topics when requested to the Women's Clubs, Parent Teacher's Association, etc.

Each medical society would have one meeting a year in a theatre or other public gathering place for the general public, at which time a program should be put on which would include a speaker and a subject, a motion picture and some music.

The Press Bureau would prepare fifty-two articles to put in the general press, starting with the larger presses such as Jacksonville, Tampa, Miami, etc.

All inquiries resulting from radio talks, press notices, etc., should be forwarded to Secretary Wells through Stewart Thompson, business manager. Box 81, Jacksonville, which inquiries would be answered through the same channels.

All radio talks, press notices, etc., are to be censored before delivery by a member of this committee. Copies of all such talks, etc., should be sent to Secretary Wells for filing and future reference. These talks, etc., whenever possible, should be sent to the secretary prior to public delivery.

This report with the outline, as suggested by Dr. Dozier, was accepted in full by the Committee. Motion, Irwin; seconded, Simmons. Carried.

Dr. Holden inquired if the rank and file of physicians could talk clearly over the radio. He was assured by several members present that it was not difficult, and that all physicians should be able to enunciate clearly.

It was decided to use as a basis for the program of talks, insofar as they would go, the subject matter as used by the Illinois State Medical Association.

It was stated that the use of the radio stations, public buildings, and press notices, etc., would have to be obtained without charge to the Association. With this end in view, the following

men were appointed to obtain use of the various facilities mentioned in their respective cities:

- (1) Dr. G. H. Edwards, Dr. H. C. Dozier, Gainesville.
- (2) Dr. Ernest B. Milam, Jacksonville.
- (3) Dr. Homer L. Pearson, Miami.
- (4) Dr. John S. McEwan, Orlando.
- (5) Dr. H. Mason Smith, Tampa.

All releases for the Press are to come through the business manager, Box 81, Jacksonville.

It is understood now and until specifically revoked by the committee that all names of speakers over radio stations be withheld, an announcement being made to the effect that, "The Florida Medical Association is speaking"; that all press notices be signed, "Florida Medical Association"; that in this report whenever an individual name is mentioned as taking charge of a certain subject, that person will write and probably deliver the subject, but in actual delivery the individual name will not appear; also insofar as possible, when various subjects proposed are delivered before local public gatherings, a speaker will be proposed and invited from an outside town by the local society in charge of the program.

Thus the committee aims to achieve its objects promoting the ideals of medicine, the health of the State of Florida and the Florida Medical Association, without in any way promoting any one individual.

It should be the duty of every member of the Committee, officers of the State Association and individual members to safeguard and promote this object. Any infringements should be reported immediately to the committee and any proposals for furthering this idea should also be proposed in writing at once.

The various appointments made to ascertain the availability of radio and press should have reports at the next meeting of the committee.

The secretary was instructed to arrange as far as possible the subjects on hand for talks; to also arrange various moving picture releases and to communicate these lists to the secretaries of all county societies in the State of Florida with the request that they reply promptly which ones they wish and can use and the probable dates so that the secretary may compile a rotating list acceptable to the various houses furnishing these releases.

Dr. Dozier requested a full committee meeting, which committee meeting will automatically include President and Secretary of the State Association, Chairman of the Executive Committee

and Business Manager, for Sunday, August 30, 1931, Hotel Marion, Ocala, Florida.

(Signed) J. RALSTON WELLS, M.D., Secretary of Committee.

FLORIDA EAST COAST MEDICAL ASSOCIATION MEETING

The committee on arrangements of the Florida East Coast Medical Association has sent letters to members of all county medical societies from Key West to Fernandina, relative to its annual meeting to be held in Jacksonville on October 3, 1931. As stated in these letters, we hope to have the best meeting, with the largest attendance in the history of the Association. The success of the meeting depends upon the quality of papers presented and the amount of enthusiasm shown by each one of us.

Many requests have been received for clinics to be held the afternoon of October 2nd in the Jacksonville hospitals. Plans for these are being made and will be announced soon.

The auxiliary is particularly active this year. The ladies are expecting many guests and will see that they are well entertained.

All committees are working out details as rapidly as possible. Several applications for places on the program have been received already. Get yours in early, in order that the program can be completed and a copy sent to you. Send your applications or suggestions to the secretary, Dr. E. C. Swift, 2033 Riverside Avenue, Jacksonville.

STATE NEWS ITEMS

Dr. A. C. Koon, Lakeland, has returned from New York City where he has been taking a four weeks' post-graduate course in operative surgery.

* * *

The regular meeting of the Duval County Medical Society was held at the Mayflower Hotel, Tuesday evening, June 2nd. Dr. Ralph N. Greene gave an interesting talk on "The Relationship of the Neurologist to the Practice of Medicine and Surgery." Dr. Raymond Sanderson gave an interesting talk on "The Aerial Ambulance—Its Use in War." Dr. J. Ralston Wells, president of the East Coast Medical Association, was a guest of the society and outlined the plans of the convention to be held in Jacksonville the first week in October. Dr. Ralph Greene introduced Major Breen of the Army Aviation Corps.

Dr. Maurice E. Heck is now up in the Pocono Mountains of Pennsylvania and expects to return to Florida in time to reopen his office in Miami on October 1st.

* * *

The Pasco-Hernando-Citrus County Medical Society held its regular monthly meeting with Dr. G. R. Creekmore as host, Thursday evening, July 9th. At seven o'clock, Dr. Creekmore invited the members over to the Tamiami Cafe where they were served a delicious chicken dinner. The vice-president, Dr. L. T. Furlow of Brooksville. presided at the scientific meeting. Drs. Jackson and Cannon each gave a case report and treatment was discussed. Dr. Creekmore had two clinical cases of skin cancer and demonstrated surgical diathermy treatment in each case. Dr. Floyd, a dentist now located in Brooksville, made a short talk and expressed his appreciation of being invited to attend this meeting and assured the doctors of his cooperation with them in every way. The meeting adjourned to meet with Dr. L. H. Dame, at Inverness, August 13th. Present were: Doctors J. T. Bradshaw, A. B. Cannon, George Dame, L. T. Furlow, T. F. Jackson and G. R. Creekmore.

Dr. and Mrs. Frank Leslie Fort of Jacksonville announce the birth of a daughter, Martha Bennett Fort, at St. Luke's Hospital, March 12, 1931.

The members of the Jackson County Medical Society were entertained with a fish dinner given by Drs. Burns and Finlay of Blountstown at Chipola Park Inn on the evening of July 14th. A paper was read by Dr. Mark F. Boyd, his subject being "Malaria." It was a very enjoyable meeting and dinner, and the society felt deeply indebted to the hosts.

Dr. S. A. Shoemaker of Orlando recently returned from a trip in the north. Dr. Shoemaker attended some very interesting clinics while in Chicago.

Dr. J. C. Davis of Quincy was recently elected president of the Chattahoochee Valley Medical and Surgical Association at its concluding session at Radium Springs, Georgia. This distinct honor coming to our Past-President Davis is of interest to the entire Association. The 1932 convention will also he held at Radium Springs.

Dr. and Mrs. D. Ward White of Miami Beach are touring New York State and Canada. Dr. White is planning to do some special study in New York City.

* * *

Dr. Lewis W. Glatzau recently changed his address from Jacksonville to DeLand, Florida.

* * *

Dr. Leland Dame and family of Inverness recently returned from five weeks' visit in Georgia and at points on the lower east coast of Florida.

On Saturday, July 11th, at the McAllister Hotel at 8 p. m., the Dade County Medical Society entertained members of adjoining societies and also President G. H. Edwards, secretary, Dr. Shaler Richardson; chairman of the Executive Committee, Dr. Gerry Holden, a member of the Executive Committee, Dr. William H. Spiers, and Dr. Stewart Thompson, business manager. A very delightful program, entertainment and social hour were enjoyed by a large number of doctors who attended. A little printed program was prepared by the Dade County Society and official invitations sent out announcing the meeting. The members of the Dade County Society are enthusiastic and comprise one of the largest societies in the state. The meeting was a marked success and the guests who attended were well pleased and went away with a friendly feeling and a closer personal acquaintance with many of our members.

Dr. Alan Brown announces the opening of his office at 417 St. James Building, Jacksonville. Dr. Brown will limit his practice to dermatology and syphilology.

* * *

Dr. and Mrs. George A. Dame and two boys of Inverness spent a week traveling in Georgia during the month of July.

* * *

The many friends of Dr. B. E. Miller of New Smyrna will be glad to learn that he has recovered satisfactorily from his recent severe illness and has resumed his practice.

* * *

Dr. Grace E. Papot announces the removal of her offices from the Comeau Building to 810 Harvey Building, West Palm Beach.

* * *

Dr. J. Radston Wells of Daytona Beach was recently elected to Senior Fellowship in the Southeastern Surgical Congress.

Dr. Frederick J. Waas, Jacksonville, recently returned from a trip to New York City.

* * *

THE DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY HAS BEEN ADDED TO THE LIST OF SOCIETIES HAVING 100% OF DUES PAID FOR 1931.

Attending the Chattahoochee Valley Medical and Surgical Association meeting held at Radium Springs, Albany, Georgia, July 14, 15 and 16, were the following members of the Florida Medical Association:

T. Z. Cason, Jacksonville.
J. C. Davis, Quincy.
G. H. Edwards, Orlando.
J. Q. Folmar, Chattahoochee.
J. G. Gainey, Jacksonville.
Ralph Greene, Jacksonville.
L. W. Holloway, Jacksonville.
D. A. McKinnon, Marianna.
W. W. Massey, Quincy.
F. C. Moor, Tallahassee.
Henry E. Palmer, Tallahassee.
H. J. Peavy, Ft. Lauderdale.
Shaler Richardson, Jacksonville.
John S. Turberville, Century.

Dr. T. Z. Cason of Jacksonville read a paper entitled "Cardiac Diseases and their Relation to Occupations."

Dr. Shaler Richardson of Jacksonville read a paper on "Strabismus with Lantern Slide Demonstrations of Operative Results."

Dr. Henry E. Palmer of Tallahassee read a paper on "Spider Bite."

* * *

The following physicians from Florida attended the Southern Pediatric Seminar at Saluda, North Carolina, in July. Out of 54 registered, Florida had 10:

J. T. Denton, Sanford.
C. H. Kirkpatrick, Arcadia.
J. D. Parker, Stuart.
H. J. Peavy, Ft. Lauderdale.
W. W. Shafer. Haines City.
B. D. Spears, Wauchula.
R. H. Stovall, Ft. Lauderdale.
A. C. Walkup, St. Augustine.
L. L. Whiddon, Ft. Pierce.
B. A. Wilkinson, Tallahassee.

Dr. Fred H. Albee of New York held a clinic at the Joseph Halton Hospital recently.

Dr. William M. Rowlett of Tampa has jouryed north and expects to spend five weeks in

neved north and expects to spend five weeks in New York and Boston attending clinics.

Dr. Rosalie Morton of Winter Park is spending her vacation in New York City.

WOMAN'S AUXILIARY

O THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

MRS. FDWARD JELKS,

2244 St. Johns Avenue

Lacksonville

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In the July Journal, Mrs. J. Ralston Wells gave us a report of the work of the A. M. A. Convention in Philadelphia. This month, we are to hear from Mrs. William G. Post, St. Petersburg, something about its entertainment features.

Your state Editor had the privilege of hearing Mrs. Walter Jackson Freeman speak concerning these prospective pleasures, at the meeting of the Southern Medical Association, in Louisville, and it was with keenest regret that we remained at home. Especially would we have enjoyed the visit to the Historical Society of Pennsylvania and hearing Dr. Burr's address, "The Daily Life of a Colonial Physician"; and also seeing that most interesting exhibition of portraits, prints, engravings, documents and old silver; then the visit to "Stenson", the home of James Logan (friend of Wm. Penn, and Secretary of the Colony) which still stands as it was built in 1728, and is now furnished with furniture of that period and its garden, "laid out as described by contemporaries."

Mrs. Post's report follows:

As I had only recently become the wife of a member of the American Medical Association, it had never been my opportunity to attend a national convention, so when my husband ar
(Continued on page 92)



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Preast milk is simple for the physician to prescribe, yet no physician ever refuses to prescribe it on account of its simplicity, its simplicity, on the contrary is one of the many advantages of breast milk. S.M.A., an adaptation to breast milk is likewise simple to prescribe and prepare and requires no modification for normal full term infants.

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LONDON 252 Regent St. W. ranged to go to Philadelphia this year I anticipated a pleasant trip, but when the time and place arrived I felt very much at a loss because I realized I was entirely unacquainted and the possibilities of meeting anyone I knew were remote. The association I had with the women in my state auxiliary had been more than pleasant but Florida is too distant from Philadelphia to expect many local members to attend the convention so that my pleasure during this time would depend upon the hospitality of entire strangers.

But I need have had no fear, for the first morning I went to the Belleview Stratford roof and found the courteous attendants directing me from one registration desk to another according to my qualifications and I realized that there was and always would be some kind voice to guide me to this or that group, from one interesting and inspiring business session of doctors' wives to that always welcome and delicious luncheon, from luncheon to some delightful drive through historic and fascinating Philadelphia, to stop at one quaint old spot or another for tea, to be rushed back just in time to dress and meet the doctors for dinner and dance or musical where the delightful contacts of the day were strengthened and increased by the husband's friends, to awaken the next morning to realize another day full of interesting events awaited you, to be welcomed in many an exclusive spot where only the chosen few have an opportunity to enter, to see the artistic and the beautiful as well as the historic wonders that a great and noble city can offer, to be lifted up and carried through an entire week of events so brilliantly planned and so well executed that only genius could bring together hundreds on hundreds of women from all parts of the United States and show each one the time of her life and send each one home richer by friends, wiser by knowledge and broader by experience of contact. All this was accomplished by the combined efforts of the women of Pennsylvania, New Jersey and Delaware.

To the Auxiliary of the A. M. A. I send greetings, to the women of Philadelphia I offer thanks for your hospitality and kindness, to Mrs. W. J. Freeman, the master mind, I wish to extend congratulations upon the complete success of the convention from the woman's viewpoint and the stranger who was made to feel at home.

FLORENCE DEAN POST.
(Mrs. William Glenn Post, Jr.)
(Continued on page 94)

DRUG ADDICTS

Drug and Alcoholic patients are humanely and successfully treated in Glenwood Park Sanitarium, Greensboro, N. C.; reprints of articles mailed upon request. Address W. C. Ashworth, M.D., Owner, Greensboro, N. C.

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Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians' Exchange, 30 North Michigan, Chicago. Established 1896. Member The Chicago Association of Commerce.

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Post graduate instruction offered in all branches of medicine. Courses leading to a higher degree have also been instituted.

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THE armpits—the feet—the hands—become disspiration. The physical result may be chafing, "heat rash," excoriation. The social consequences may be equally distressing, for perspiration often leaves in its wake an odor quite unpleasant. For those suffering from excessive perspiration

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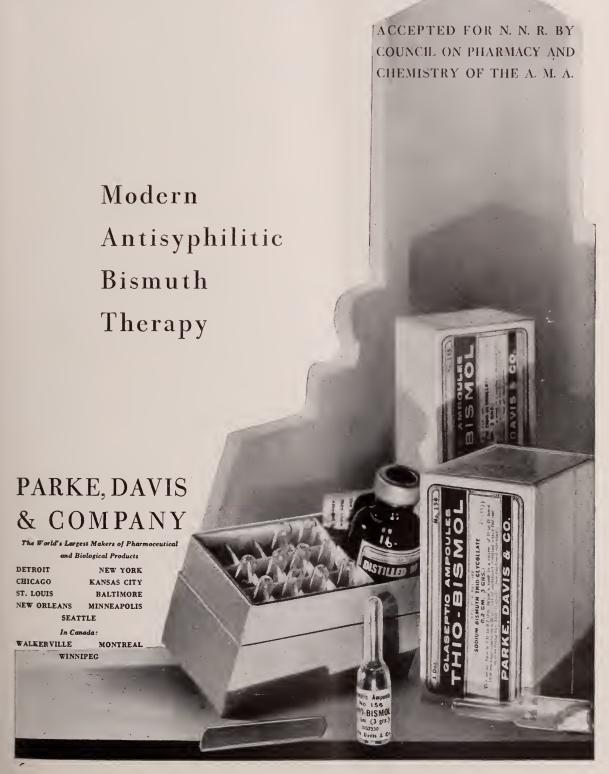
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may be safely prescribed or recommended. It checks excessive perspiration and prevents the odor, too. It needs to be applied only once or twice a week to those parts of the body not exposed to adequate ventilation.

Trial supply gladly sent to physicians on request.

YES, I'd like to	o try NONSPI. Please send me a free trial supply.
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THIO-BISMOL



News Items

On June 15th, Mrs. Henry Hansen, of Jacksonville, sailed from New York for London, England, her native home, where she expects to spend the summer.

* * *

On Wednesday, July 1, Mrs. S. E. Driskell and Mrs. Edward Jelks of Jacksonville, motored down to Daytona Beach for a visit at the beautiful home of Mrs. J. Ralston Wells. They were joined there by Mrs. J. E. Taylor, of DeLand, for luncheon. The hostess, Mrs. Wells, was assisted in entertaining by her mother, Mrs. White, of Tennessee.

PANORAMIC VIEW OF THE WOMAN'S AUXILIARY TO THE A. M. A. IN FOUR ARTICLES

1. THE EASTERN DISTRICT Mrs. W. Wayne Babcock

New Hampshire stands alone as the only New England state 100% organized and cooperating with the National Organization.

The New Jersey Auxiliary made pilgrimages to state institutions, set apart one meeting when the mothers of physicians were entertained, and sponsored various health meetings. The Essex County Auxiliary, assisted by the physicians, succeeded in establishing a course of health talks, in cooperation with the Y. W. C. A. of Newark, emphasizing especially prenatal care and information which would aid the mothers of babies and young children.

Virginia is active in spots. The doctors encourage the auxiliaries as they believe that through them education with regard to the menace of state medicine can be spread.

Ohio for several years has been sending representatives from a few organized counties to the national meetings but as yet there is no state organization.

The District of Columbia seems so completely diverted with Washington affairs that the auxiliary which so capably cared for the A. M. A. meetings some years back seems to have gone into retirement.

Delaware in a breathless, better-late-than-never manner, has completely caught up and is most interested and active and has entered upon serious work by assisting the men of the profession in establishing a medical library in Wilmington.

(Continued on page 96)

J. K. ATTWOOD, Pharmacist

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NERVOUS DISEASES

LOCATED IN THE EASTERN SUBURBS OF THE CITY. SIXTEEN ACRES OF BEAUTIFUL GROUNDS. ALL EQUIPMENT FOR CARE OF PATIENTS ADMITTED.

William D. Jones

Pharmacist

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Jacksonville, Florida

from the laboratories of
HOFFMANN-LA ROCHE
Makers of Medicines of Rare Quality



DIGALEN 'Roche'. . for the heart

They cooperated with Philadelphia at the time of A. M. A. and the eastern section introduced them with pride to the National Organization. West Virginia is up and doing and you may expect still better things from that State this year.

Maine, Massachusetts, Rhode Island, Vermont and Maryland have reported the interest of individuals but no organized effort. Queries from different localities in New York as to why there is no auxiliary have been answered with the statement that several years ago the House of Delegates voted unanimously in favor of the auxiliary and authorized its organization. The same year Connecticut voted favorably but no definite steps have been taken.

Pennsylvania has surely discovered the rhythm in which its auxiliary work is best done, for concrete accomplishments have been turned out regularly, year by year. Of the three thousand dollars contributed last year to the Medical Benevolence Fund more than two-thirds was contributed by the Auxiliary.

ADVERTISERS' NOTES

Shakespeare wrote of the caprices of sleep, and the anguish of those whom it eludes: "Cans't thou. O partial sleep, give thy repose to the wet sea-boy in an hour so rude and in the calmest and most stillest night . . . deny it to a king?"

The echo of this complaint, couched in one form or another, is heard daily by almost every physician, from patients who reflect the strain imposed by the accelerated modern tempo of living. To them the balm of sleep is denied. They tell of sleepless nights, or of interrupted and restless slumber which leaves unfulfilled its duty of restoring strength to an exhausted body. The need for relaxation, for tranquil sleep, is perhaps more noticeable now than ever before.

Inability to sleep may be due to many causes: hypertension, mental strain, nervousness, hyperthyroidism, drug addiction, alcoholism, or other factors.

Amytal (iso-amyl ethyl barbituric acid), a product of the Lilly Research Laboratories, meets the need for hypnosis and sedation in a wide variety of cases. Since its introduction to the medical profession a few years ago, Eli Lilly and Company report that there has been an everincreasing demand for this safe and satisfactory hypnotic and sedative. Recently, in response to

(Continued on page 100)



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NERVOUS AND MENTAL

A modern neuropsychiatric hospital with special laboratory facilities for the study and treatment of early cases. Also a department for the treatment of drug and alcoholic addictions.

The Sanitarium is located on the Marietta Electric Car Line, ten miles from the center of Atlanta, near Smyrna, Ga. The grounds comprise 80 acres. The buildings are steam heated, electrically lighted, and many rooms have private baths.

Address communications to Brawner's Sanitarium, Smyrna, Ga., or to the city office, 478 Peachtree St., Atlanta. Ga.

DR. JAS. N. BRAWNER, Medical Director. DR. ALBERT F. BRAWNER, Resident Physician.

__XX

BANKRUPT SALE

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Trustee for Guyer X-ray Company,
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the demand for a smaller dosage to produce sedation in ambulatory cases, the Lilly Laboratories made available Tablets Amytal, Half Strength, in 3/4 grain tablets.

Tablets Amytal are sold through the drug trade. Inquiries for further information may be addressed to Eli Lilly and Company, Indianapolis.

During the hot weather, when fat tolerance is lowest, many physicians have found it a successful practice to transfer cod liver oil patients to Mead's Viosterol in Oil 250 D.

Due to its negligible oil content and its small dosage, Mead's Viosterol in Oil 250 D does not upset the digestion, so that even the most squeamish patient can "stomach" it without protest.

There are at least two facts that strongly indicate the reasonableness of the above suggestion: (1) In prematures, to whom cod liver oil cannot be given in sufficient dosage without serious digestive upset, it is an uncontrovertible fact that Viosterol in Oil 250 D is the antiricketic agent (2) In Florida, Arizona and New Mexico, where an unusually high percentage of sunshine prevails at all seasons, Mead's Viosterol in Oil 250 D continues increasingly in demand, as physicians realize that sunshine alone does not always prevent or cure rickets.

Mead Johnson & Company, Evansville, Ind., invite you to send for samples of Mead's Viosterol in Oil 250 D for clinical use during the summer months to replace cod liver oil.

Cocomalt, the new chocolate flavor food concentrate, is rapidly gaining favor among the medical profession, as evidenced by its increased sale to hospitals and institutions.

Splendid results have been reported in general cases of malnutrition; but especially among children has Cocomalt convincingly proved its power to quickly add weight to the malnutritious child. By actual test Cocomalt adds 70% to the caloric value of milk. Yet it is so easily digested, so readily absorbed, that it is acceptable even to the most weakened digestive system. Furthermore it contains malt enzymes which help to digest the starches in other foods.

The makers of Cocomalt particularly wish to remind doctors and nurses that Cocomalt is not a powdered chocolate, not a malted milk, not cocoa, but a scientific food-concentrate of high nutritive value.



See Description, Journal A. M. A. Volume XLVII, Page 1488

scientific combination of Bismuth Subcarbonate

A scientific combination of Bismuth Subcarbonate and Hydrate suspended in water.

Each fluidrachm contains 2½ grains of the combined salts in an extremely fine state of subdivision.

Medicinal Properties: Gastric Sedative, Antiseptic, Mild Astringent and Antacid.

Indications: In Gastro-Intestinal Diseases, Diarrhoea, Dysentery, Cholera-Infantum, etc. Also suitable for external use in cases of ulcers, etc.

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A characteristic of Mead's Powdered Lactic Acid Milk No. 1 (containing Dextri-Maltose) is the finely divided soft curd which never clogs the nipple. In a few moments, any mother can carry out the simple procedure required without error — a saving in time to her and an assurance to the physician that the feedings are correctly prepared. This product never curdles; it is always ready, and quickly reliquefied. No ice is necessary to keep the powder. It is convenient while traveling. Samples and literature on request. Mead Johnson & Company, Evansville, Indiana, U.S.A.

SCHEDULE OF MEETINGS—COMPONENTSOCIETIES FLORIDA MEDICAL ASSOCIATION

3(1)	TEDULE OF MEETINGS	COMPONENTSOCI	IL TILS ILO	KIDA WEDICAL A	SSOCIATION	
COUNTY	SECRETARY	Date	MEI Time	ETINGS	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday		White House	Yes.	73%
Bay	D. M. Adams, M.D., Panama City.					100%
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		80%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Corn-	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		71%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally.	50%
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	94%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	77%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	76%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	69%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna.	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	79%
Madison	Geo. O. Davis, M.D., Madison.					67%
Manatee	A. Q. English, M.D., Manatee.	Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	64%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Court House	Yes.	88%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every other Friday	8:00 P.M.	500 Power & Light Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeache- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
Washington- Holmes						



Summer will soon be over and children will be leaving play to take up their studies in school. At this time, physicians are calling the attention of parents to the need for immunizing their children against smallpox and diphtheria.

In the important work of prevention and treatment of smallpox, diphtheria, and other diseases, the House of Squibb has for many years been supplying the medical profession with the finest biological products that painstaking care and skill can produce.

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LUME XVIII NO. 3

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weight, spasticity of arms and legs, rigidity of neck, restlessness, pallor, low hemoglobin. The vitamin B factors are provided by the addition of extracts of wheat embryo and yeast. 1gm. is equivalent in vitamin B complex to .4 gm. dried yeast or .8 gm. wheat germ.

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LL WORKS OF QUALITY MUST bear a price in proportion to the skill, time, expense and risk attending their invention and manufacture. Those things called dear are, when justly estimated, the cheapest; they are attended with much less profit to the builders than those which everybody calls cheap. Beautiful forms and compositions are not made by chance, nor can they ever, in any material, be made at small expense. A composition for cheapness and not for excellence of workmanship is the most frequent and certain cause of rapid decay and entire destruction of arts and manufactures.

-RUSKIN

SHOULD x-ray and physical therapeutic equipment fall into the class of equipment that can be shopped for? A serious question this, these days when bargains of all sorts are offered at prices that allure.

But if tempted, remember this: to accept a diagnostic or therapeutic device which falls short in any degree of giving the patient the full benefit of what science has made possible through such a device, is a mistake.

For more than a third of a century this company has specialized in the designand manufacture of x-ray and other electro-medical apparatus. This vast experience has placed us in a position to appreciate the importance to physician and patient of such equipment.

Thousands upon thousands of users of Victor products the world over will attest their complete confidence in every apparatus which bears our mark. They know that Victor equipment is made to meet the purpose and not to meet a price.

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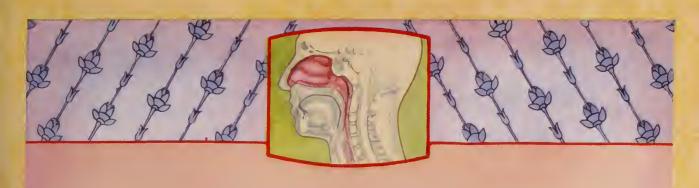
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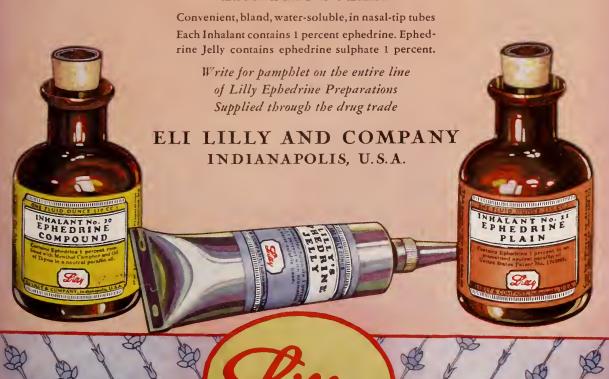
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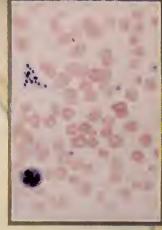
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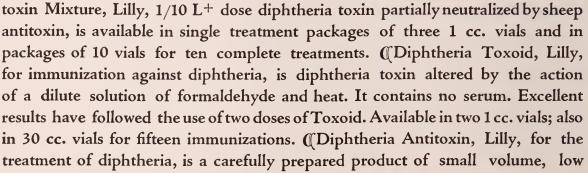
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SOME OBSERVATIONS ON APPENDICITIS* JOHN S. McEwan, M.D., Orlando.

There were 2,176 appendectomies performed by the Orlando Clinic to April 30, 1931. In reviewing these cases, a great many interesting facts were found, especially in the diagnosis: differential diagnoses, operative procedures, complications and causes of mortality. A paper discussing all these would necessarily be too long, so I am confining myself to a few of the most important points, as I see them.

The late John B. Murphy said that if you had a patient who complained of pain (abdominal) followed by nausea or vomiting, tenderness in appendiceal region and temperature, the symptoms coming in that order, you had an acute appendix, of course, ruling out pelvic diseases in women. This is still true, but I wish to go into a little detail regarding the two most important symptoms: pain and tenderness.

Any pain originating over the appendix may be looked upon as not suspicious of appendicitis, unless the reverse can be proven, while a pain beginning all over the abdomen should be regarded as a sign of probable appendicitis, even before it locates in the right lower abdomen. It is the earliest, most constant and the most essential symptom. Ninety-nine times out of a hundred, the pain is general at first, beginning in the epigastrium, the umbilical or rarely left side. Because of its sudden onset, most patients think they have an ordinary colic or "belly-ache", but after a period of time, from six to twenty-four hours, it localizes in the right lower quadrant and persists until the attack ends itself normally or by the incidence of tragic pathology. As the pain continues it may become a steady dull ache, assume an intermittent quality and in very mild attacks subside in an hour or two. It is increased by change of position, jarring of the body, the upright position and pressure of the hands. Turning on the left side is especially apt to increase the suffering. Because of this maneuver, the

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931. right colon drops inward, causing great displacement of the appendix and traction at its attachment.

The degree of pain differs notably. It bears no relation to the pathological changes in the appendix but, as a rule, the most intense suffering is seen in the fulminating types showing rapid development of the morbid process. Many times, however, complete sloughing of the appendix is found when the initial pain was light and shortlived. The temperament of the patient will have much to do with the subjective manifestations of the pain. Some will complain bitterly and react excitedly in the presence of slight suffering, while others will endure with complacence the most violent agony. It is useful to take account of this personal equation for one might become alarmed unduly and thrown off the track by the former individual or fail to grasp the situation in the

There is no more delicate matter in the observation of appendiceal patients than the elucidation of the incipient pain and of its relation to other symptoms. More significant than the degree of pain is its duration. There is no rule to follow as guide. In a typical, mild attack, the pain begins to subside after twenty-four hours and is practically gone in forty-eight, unless some untoward and unusual phenomena shows up—The tendency is to recovery from the acute attack.

As the pain steadily increases, denoting more and more distension with edema and infiltration of appendiceal walls, either the appendix is removed or ruptures. In the presence of continuing pain it is safe to suppose that the appendix is intact no matter what the duration of the pain. When the pain subsides slowly after rather a short time and with no cessation of other symptoms, gangrene may be suspected; when the duration is longer and the symptoms are declining, recovery from the attack may be predicted. If the pain ceases suddenly, especially after a marked increase in severity, perforation is probable. This is the most serious disaster that can befall the patient and it may be averted by a proper understanding of the significance of the pain. Pain is a pointing of nature, a reliable index that something is

wrong. If we judge it correctly and follow its lead, a safe issue most likely will follow. Above all it must be remembered that in acute appendicitis, the abrupt relief from pain does not mean necessarily that the patient is better, as very often he is worse. A false sense of security has caused countless fatalities.

The special tenderness associated with acute appendicitis is elicited upon pressure applied directly over the inflamed appendix. It varies in times of appearance, in grades of severity and in relative position. In the early hours of an attack, there is superficial hypersthenia all over the abdomen, corresponding to the diffused pain. Soon this cutaneous tenderness disappears and a marked response to pressure develops in the right lower quadrant. Often this will appear before the pain itself has localized in that region.

It is vitally important to keep in mind the distinction between pain and tenderness: the first subjective, unrelated to external influence, and the second objective, evoked by pressure and modified by its character and degree. It is still more important to realize that the tenderness may be where the pain is not. This is especially significant among the early manifestations where severe pain is commonly located at the epigastrium or around the umbilicus and marked tenderness is produced by pressure in the right iliac region. In most instances such pressure increases the pain at the point where complaint is made serving to produce connection between lesion and symptom. degree of response to pressure over the tender area is contingent upon the perceptive impulses of the patient, the period of the disease, the depth of the inflamed part from the surface and the method of applying the pressure. The personal psychological reaction enters largely into the matter also. The tenderness gradually becomes intensified from the time of its appearance and at the end of twenty-four hours generally is at its height. Just as the pain may cease suddenly, or gradually in certain events, so the tenderness may fade away quietly or leave suddenly.

As an almost fixed rule, the nearer the inflamed appendix to the parietal peritoneum, the more acute the tenderness. Granting that a deeper seated lesion of greater severity were present, its response to pressure would not be so marked as a lesser lesion nearer the wall. The intensity of response to pressure may be no index whatever to the extent of the lesion. The point at which the tenderness exists in its maximum intensity is

a question of great interest and moment. As a universally accepted observation this area corresponds to the base of the appendix, for it is there that the nerve distribution occurs with which the different nerves from the appendix unite to convey their sensations back to the spinal ganglion.

Every surgeon of experience knows that there is a wide variation in the exact spot of greatest tenderness, just as the position of the appendix varies in health and disease. In determining the sensitiveness to pressure, the clinician is more interested in its diagnostic aspects than in its definite anatomical position. First, locate the spot by careful palpation and there the appendix will be found.

Fowler's opinion that it is difficult to estimate the exact diagnostic value of the leucocytosis is at the present time as true as it was in 1900. From our own findings and from the study of the literature, the following conclusions may be summarized: The height of the leucocytosis bears no relationship to the severity of acute appendicitis. The white cell count does not run parallel to the different stages of the pathological process. The practice not to advise operation unless there is a marked increase in the number of leucocytes is dangerous for the patient. By repeated white cell count, very little will be gained in our knowledge about the patient's condition, because spontaneous changes in the number of leucocytes are physiological. Appendectomy must never be undertaken or deferred on the basis of the blood count alone. Leucocytosis is a minor symptom of appendicitis, inconstant and unreliable. A high polynuclear count, however, is indicative of a severe infection.

In glancing over our operations, I was struck by the increased mortality in children and in looking up their series of operations, I find that many writers have reported mortality rates varying from 9.7% to 33% and have noted that the mortality is markedly higher than in adults. In attempting to account for this, many reasons have been advanced, but by subjecting these to a critical analysis, it would seem possible to reduce them to five which are inclusive and fundamental and which we may term mortality factors. They are first, difficulty of diagnosis; second, delayed medical attention; third, the misuse of purgatives; fourth, physical conditions peculiar to children; and fifth, poorly timed and poorly executed operations.

Why is the diagnosis difficult? The reasons most frequently heard are that children are constantly having more or less pain in the abdomen, that they vomit at the least provocation and from a large variety of causes, that acute respiratory infections and acute contagious diseases are often initiated with abdominal symptoms. Children are so hard to examine satisfactorily.

Does the normal child have frequently recurring pains in the abdomen? Certainly not. Such pains call for a determination of the causative factor, whether it be appendicitis, dietetic irregularity, enteritis, respiratory infection, inflammation of extra-abdominal structures or other causes. The fact that children frequently do have pains in the abdomen, with or without vomiting, cannot be used as a cloak behind which we may hide, if we have failed to eliminate appendicitis as a cause.

The difficulty in differentiating an acute respiratory infection from appendicitis is occasionally great. This is a real diagnostic hazard, and frequently necessitates a most careful estimation of the physical and laboratory findings and the history of previous attacks or exposure to respiratory or contagious disease. Failure to obtain a satisfactory examination of the patient is rarely excusable.

Delayed medical attention has a distinct influence upon the mortality rate. This is a difficult factor to control because fundamentally it depends upon the observations and judgment of untrained minds, complicated by social and financial conditions. The business of raising children is usually undertaken by a person who has had no preliminary training whatever, who has no qualifications beyond an intangible maternal instinct, and whose usual source of information consists of a mother or friend who has had a series of perhaps three or four cases upon which to base her advice.

It is hard for the average mother to know when to call the doctor. In many localities the cults have effectively prevented her from obtaining any knowledge of anatomy and physiology in our public schools. If she has been so fortunate as to have gone to college, she probably is not one of the few who have taken a course in home nursing but is one whose only knowledge of the contents of the abdomen has perhaps been gained, when with half averted eyes, she has hastily transferred the entrails of a chicken to the garbage can. If, in addition to possessing this foundation for making a physical examination, she is the watch-dog of

the family exchequer and knows the cost of medical services, it is not surprising that she puts Willie to bed with a dose of castor oil, and waits a day or two before calling the doctor. The serious consequences of this delay are too frequently before us to require further comment. The factor of delayed medical attention has a great influence upon the mortality rate and it can be reduced only by persistent education of the laity.

The misuse of purgatives causes a sharp rise in the mortality rate, and while the influence of this factor has frequently been called to our attention, the results which are constantly appearing upon the operating table would seem to warrant further emphasis. Through recent efforts of the American College of Surgeons, movies have been made available for medical groups which show the state of constant intestinal unrest produced by peristalsis in the normal abdomen, and which make it easy to picture the veritable lashing of the intestines which must follow the use of irritant cathartics. The effect of such action upon an inflamed, edematous appendix, about which nature is endeavoring to build a protective isolation of adhesions is all too clear as is almost the rapidity with which a localized peritonitis would be converted to a general one.

The purgative factor in the mortality is due largely to the home conditions already discussed and while the hope of reducing it depends to a great extent upon the education of the laity, a large measure of responsibility is ours to see that we eliminate the possibility of appendicitis before prescribing cathartics.

Physical conditions peculiar to children which are most often cited are: the omentum short, thin and incapable of affording protection; the peritoneum more susceptible to infection than in the adult; the appendix more easily perforated; the child generally not able to stand infection well. Of these the most important is early perforation, a factor difficult to reduce, except perhaps by the persistent education of the laity already mentioned. The bearing of the other conditions upon mortality does not stand close analysis. To be sure, the omentum is short and thin, but not disproportionately so. We certainly would not expect to find an omentum of the adult size and tensile strength in an infant. Its protective ability also is excellent, as can be attested by any one of us who has attempted to separate omental adhesions in an infant or small child. The failures of the omentum to protect can be laid to early perforation, because rupture of the peritoneal surface has followed so closely upon peritoneal irritation that there has not been time after the first chemotactic hurry-call for firm adhesions to form.

Is the peritoneum more susceptible to infection? This is hard to believe after repeatedly seeing cases recover as soon as proper drainage and removal of infectious material has given the peritoneum an even chance. Here, again, the instances where peritoneal resistance breaks down are those in which early perforation or delayed medical attention has permitted massive infection to overcome resistance.

Does the child generally stand infection poorly, or in other words, is his resistance usually low? Such a contention is almost absurd. It is well recognized that the resistance of nurslings is so high that they rarely contract contagious disease. The resistance to diphtheria and scarlet fever, as shown by the specific Schick and Dick tests, is greatest in early childhood. In children the reaction to vaccination is usually mild, indicating a certain amount of resistance even to smallpox. Why, then, should we, in the face of the fact that all known specific tests of resistance rate the child high, contend that his resistance is low to pyogenic bacteria and colon bacilli which normally inhabit his skin and alimentary tract and to which he should, therefore, have developed an almost specific resistance? The answer is not a normally low resistance but rather a massive infection from early perforation overcoming a normally high resistance. The mortality factor arising from the physical peculiarities of children resolves itself into the control of early perforation and hence is a most difficult one to reduce.

Another fact we have noticed in going over our cases is that very often a combination of appendicitis, disease of the biliary system and a gastro-duodenal ulcer occurs. The majority of surgeons admit the difficulty in a large percentage of cases, to determine, before the operation with the aid of all the diagnostic means, if the stomach and duodenum and the gall-bladder and the appendix as well participate in the clinical picture or which of them is its cause. In many cases, even the operation does not clear the situation in regard to the genesis.

Our attention has furthermore been drawn to the fact that post-operative complaints were often due to the affection of an organ other than that which had been operated on. Thus, many appendectomized patients later suffer with a disease of

the biliary or with gastric and duodenal ulcers, and complaints after an operation on the biliary system as the gastroduodenal tract, have often only been finally relieved by a secondary appendectomy. All these very difficult problems can only be approached by inspecting, during an operation upon the abdomen, the stomach, the duodenum and the gall-bladder and if possible, to expose the appendix as well. This is technically possible in almost all the cases in which a median incision or a right rectus incision has been made. The most frequent combination in our experience is cholecystitis and appendicitis; the next gastroduodenal ulcer and appendicitis and the least percentage, gastroduodenal ulcer and gall-bladder and appendicitis.

I believe that the appendicitis was the primary infection in these combined cases, but in cases where the appendix has been removed first, the gall-bladder or gastroduodenal disease has followed. We also believe that certain individuals are predisposed to abdominal disease. The defensive power of the peritoneum varies extensively. There is also a familial predisposition to appendicitis. Members of the same family, who had to be operated on for abdominal disturbances showed the same anatomical peculiarities of the appendix, excessive length, location, kinks, torsions, etc. In the time previous perhaps to 1921, these combined infections were not noted, but since that time with a systematic examination these conditions have been recognized.

The Ochsner treatment has, in many cases, already been adopted before the case comes into the hospital and the time for temporizing has passed. There are so many factors which conspire to cause a fatal termination, that is virulence of the infecting organism, resistive powers of the patient which can not be accurately assayed, that one regards with suspicion so dubious a guide as the supposed danger period between the second and the sixth days. The reality of an especially perilous period, between the loss of the natural immunity and the calling up of the protection conferred by an acquired immunity, is in consonance with the theory of a negative phase, but that this occurs with sufficient certainty between the second and the sixth days, to dictate treatment seems to rest upon too slender a foundation of academic speculation to warrant any deviation from the path outlined by the physical signs. In the race between the rising virulence of the poison and the patient's powers of resistance, the danger

period comes to one case within a few hours, to another it may never come at all. There can never be, in any case capable of spontaneous resolution, any period of absolute loss of immunity, else would the patient surely die. During the period of lowered immunity, a period that varies in onset and duration and degree with every patient, the only sure guide is the clinical picture; it is possible that the operation may still be safe during this period provided certain details of technique are adopted.

Our records show that the mortality in early operation, that is the first twenty-four hours, is practically nil, 1/2%; that every day's delay increases the mortality rate.

The latest available government statistics show that there were 17,433 deaths from appendicitis in 1928. The rate per 100,000 estimated population is 15.2%. Although an increasing mortality rate according to vital statistics is reported, the operative mortality rate for appendicitis has decreased. The average operative death rate for the years 1902 to 1910 was 7.6%; for years 1910 to 1920 was 5.7%; for years 1920 to 1929 was 3.5%.

Probably one of the chief causes of the still high mortality is the fact that medical treatment is always given when it should be surgical. Indecision and procrastination on part of physician and patient, their failure to realize the seriousness of the condition and to institute radical treatment before the disease reaches the drainage stage are the main causes of mortality.

Early diagnosis followed by immediate appendectomy offers the best hope for the reduction of the mortality rate in acute appendicitis.

To castigate the public with the hope of improving conditions is a negative procedure, in fact it is pharisaical because there still exist surgeons, who permit cases of acute appendicitis "to ride" until a time convenient for operation. Amelioration of mortality figures will occur when surgeons, particularly part-time surgeons, realize that even in the complicated cases recovery is the expected outcome.

In our own personal experience, we have been able to hold the mortality to a very low point. This has been due to several factors, the principal one being that the doctors in this section of Florida make early diagnoses, warning the patients in time. No surgical procedure can take the place of early diagnosis.

It becomes increasingly evident that the reduction in mortality will only be effected by greater

precision in diagnosis, earlier operation, a more lively appreciation of the serious nature of the disease and by a standardization of technique, especially by the abandonment of those obsolete methods of approach which give too limited an exposure or scope.

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DISCUSSION

Dr. F. J. Waas, Jacksonville:

This is a very timely paper, especially now that we are elaborating so much on the mortality of appendicitis.

The mortality from appendicitis is still increasing. In Philadelphia between 1913 and 1923 the mortality increased 18%. Out of the first year's check-up it was found that 207 deaths were due practically to purgatives. Seventeen thousand cases died in 1929 in the United States, and of these 12,000 had purgatives, and 11,000 of these probably died as a result of purgatives. Procrastination and purgatives are two of the greatest dangers we have in combatting the mortality of appendicitis. I am quoting from Dr. Hubert Royster in the Journal of the Southern Medical Association. Royster states that "the attack is the knock at the door." In other words I feel that the pain is the knock at the door.

In a recent study made by Dr. Jeff Miller of 239 deaths from appendicitis collected from the records of the Charity Hospital and Touro Infirmary at New Orleans, more than 42% of the deaths had purgatives. A contributory fact in connection with these figures is that many more patients, 17% more, to be exact, had treated themselves in this fashion in preference to calling the doctor, and a second astounding fact is that in 12.6% of these cases the purgative was taken on the advice of a medical attendant. The physician must know, even if the lay person does not, that

abdominal pain can be the precursor of many serious surgical diseases, and that it is most often the precursor of acute appendicitis in which purgation is akin to suicide. Castor oil especially and purgatives in general should never be given in the presence of abdominal pain. A good slogan for druggists to adopt or post in a conspicuous place in their pharmacy would be "never give purgatives in the presence of abdominal pain. See your doctor first."

The pathological appendicular syndrome of pain, nausea, vomiting, temperature, tenderness and abdominal rigidity should be changed to nausea, vomiting, then pain, and if this pain is not relieved by vomiting or emesis, in other words, if it is aggravated by vomiting, you can assure yourself that you have a beginning peritonitis, or in inflammation of some abdominal viscus. The pain, to my mind, is the result of the insidious pathology that may have been existing for twelve or even twenty-four hours before pain manifests itself. Dr. Royster definitely states that "pain is the attack and the attack is the knock at the door." It is nature's warning to get busy.

Relative to the blood count, in children it is especially confusing. We frequently find a ruptured gangrenous appendix in a child with a very low blood count. It is undoubtedly due to a depression of the myleocytic response. I believe in many instances this myleocytic depression will hold good in adults, so do not attach all the importance to the blood count, especially if you are expecting a typical leucocytosis.

Dr. John S. McEwan, Orlando (concluding):

I wish to thank Dr. Waas for his discussion. In a short paper like this, it would be impossible for me to discuss the complications, differential diagnosis, treatment, etc. It is a great satisfaction to us surgeons to know that, although the mortality rate is increasing, our operative mortality rate is decreasing.

There are three things that are increasing our mortality rate: purgatives, which are prescribed by druggists for "pain in the belly"; the increasing number of quacks in Florida; and the fact that many doctors have, perhaps, too great a tendency to let their patients "ride for awhile," if they are busy, and this delay is always expensive.

In this section of Florida we have a group of physicians who make an early diagnosis and believe in early operation.

HEAD INJURIES* HAROLD D. VAN SCHAICK, M.D., Jacksonville.

Skulls dating from the Neolithic age of about 12,000 years ago have been found that have been trephined. The controversy concerning the treatment of fractured skulls has occupied probably most of that period of time and will continue until some semblance of order comes from the disorder and misunderstanding that surrounds the subject. To speak of fractured skulls when we mean injuries to the skull, the meninges, or the brain is merely an example of the confusion that attends the whole group of head injuries.

The treatment of this condition has heretofore been aimless and haphazard without the guiding star of sound physiological and pathological knowledge. However, of late there are emerging slowly certain facts and procedures which commend themselves to us and sooner or later must be accepted by those desiring the best for their patients.

First: A knowledge of the circulation of the cerebrospinal fluid and the mechanism of increased intracranial pressure is absolutely essential and is the foundation upon which all treatment is based. The cerebrospinal fluid, as far as we know, is an active secretion of the choroid plexus mainly, and the metabolic products of the brain cells themselves through their perivascular channels.

There is a definite circulation from its origin in the lateral ventricles through the foramen Monroe to the third ventricle, then through the aqueduct of Sylvius to the fourth ventricle, where it escapes through the foramina of Magende and Luschka to the subarachnoid spaces beneath the tentorium and the large cisterna at the base of the brain.

From the cisterna, the fluid follows two paths mainly. The larger part rises over the surface of the brain through the incisura tentorii and is absorbed chiefly into the large venous sinuses by means of the pacchionian bodies. The smaller portion descends along the ventral aspect of the cord and returns along the dorsal aspect. These two streams are partly separated by the ligamenta denticulata and the spinal nerves.

Thus, the main path of the cerebrospinal fluid is from the ventricles within to the cisterna at the base, thence through the cleft in the tentorium

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

outward over the surface of the brain into the subarachnoid spaces. The cause of this flow is the force excited by the secretion in the plexuses aided by gravity and pulsation in the brain and a lower pressure in the dural sinuses than in the subarachnoid spaces.

The normal circulation of the cerebrospinal fluid may be disturbed by a number of factors but here we are concerned only with those caused by acute injuries. Ninety to ninety-five per cent of all severe head injuries, with or without fracture, sustain damage to the brain itself or to its coverings. This injury may vary from mere contusion of the contents, rupture of small vessels in the meninges, or brain substance, and minute hemorrhages here and there, to massive extravasation of blood and laceration.

The mechanism of increased intracranial pressure or traumatic edema begins at the time of the injury. There is first a disturbance of the vessels, then retardation of the current, followed by extravasation of their contents. This is aided by whatever hemorrhage may be present either outside or underneath the meninges. Cells deprived of oxygen absorb fluid, causing them to swell. The outer coverings of the brain being unvielding the subarachnoid space is the first to suffer. This being the main channel for the normal escape of cerebrospinal fluid on its way to absorption, its loss causes a damming back or pooling in the large cisterna at the brain base, below the tentorium. The cerebrospinal fluid continues to be secreted in the ventricles and pools in the cisterna forcing the medulla upward. This tends to occlude the narrow subarachnoid spaces in the incisura tentorii and further stasis occurs. The stasis or anemia in the brain calls upon the centers in the medulla, the blood pressure rises sufficiently to force blood through the cerebral vessels again. This in turn causes an increase in the condition of stasis already existing in the brain. Again, there is a corresponding rise in blood pressure. This continues until the medullary centers are exhausted and a condition of medullary exhaustion supervenes and the patient passes away.

This cycle must be broken at a point below the tentorium early enough to prevent death or even should death not occur and the pressure be allowed to remain, degenerative changes take place in the cortical cells with a resultant gliosis.

This also explains why many patients pass away even following a large well-performed craniotomy for the relief of pressure. Upon opening the dura and arachnoid there is a sudden gush of fluid. The brain seeking relief from the pressure within is gradually rolled outward, until it fits snugly against the edges of the bony opening. The subarachnoid space is again closed and favorable conditions for the increase of pressure are again present.

Second: We must realize that patients do not die of fractures of the skull. They may expire from shock, hemorrhage, increased intracranial pressure or infection but not from fracture. Therefore, unless depression or compound fracture occurs it may be almost disregarded and our attention directed entirely to the brain injury. With this knowledge, we may proceed now to the consideration of the main points in the treatment.

A patient presents with an acute cranio-cerebral injury. He should be seen immediately by the physician in charge and a thorough examination made of the entire body as concomitant injuries must not be overlooked. If shock is present, proper treatment is instituted as, ordinarily speaking, a patient that will die within six hours will die regardless of what is done.

Valuable time should not be lost in the installation of proper remedial measures while waiting for an X-ray or the reading of an X-ray film. It is better, when possible, to use a portable X-ray and take the films in bed thus avoiding additional injury from transportation to and from the X-ray department. Under no circumstances should such a patient be allowed to lie on a roller or table waiting for his turn for *any* laboratory procedure. Surgery should be done only when indicated definitely as unnecessary decompressions through added trauma to the brain substance or unchecked oozing of blood may be the deciding factor against recovery.

The indications for operation are:

- 1. Severe depression or depression with focal symptoms. Surgeons generally have elevated all depressed fractures. However, as early as 1811, Abernathy, and later others, doubted this necessity. Of late, Naffziger and Glazer have shown experimentally in rabbits that the harm is not done by the depression in the bone but by the force producing the injury. Therefore, slight depressions without symptoms, unless over the motor or sensory area, should be left alone. All others should be operated at once.
- 2. Compound fractures. These should be cleaned, debridement performed and closed with a small rubber dam drain.
- 3. Massive hemorrhage usually middle menigeal (5%) should be operated when diagnosed and

suspected by slowing of pulse, rising blood pressure, fixation of pupil, gradual hemiplegia or convulsive attacks beginning in the face and extending to the leg and arm in the order named, bilateral rigidity, paraplegias, etc. Small hemorrhages with focal signs usually occur immediately underneath the point of injury or directly opposite by contra coup. These may be allowed a few hours' leeway as a decompression from increasing pressure may become necessary later and then both results accomplished at the same time.

4. Increasing intracranial pressure in spite of treatment. This will be manifest by a rising temperature and pulse and increasing restlessness or deepening coma and choking of the disks, or irregularity of the pulse and respiratory rate. Adson has recently noted another significant sign and that is the approach or crossing of the pulse pressure and rate. Spinal punctures and the dehydrating measures should continue as before. When seen late and medullary compression is present, the only possible chance for life is the performance of cisterna magna puncture with patient in the Trendelenburg position followed by suboccipital decompression.

Morphin should not be given except early in shock with rapid pulse and low temperature, or after decompression. Certainly it has no place in the treatment previous to decompression as it is given usually for restlessness, a sign of cerebral irritation, and not for pain. Cerebral irritation manifest by increasing restlessness as brought out by Dandy means the patient is either coming out or is going deeper into coma, in other words, a break in the compensation that nature provides for certain degrees of increased intracranial pressure. If the latter is occurring, nature is trying to tell you that something further must be done in the very near future or disaster in the form of medullary exhaustion is at hand.

It is well for each individual to work out the plan of procedure which best suits his own needs. Ours is as follows:

- 1. Examination and X-ray.
- 2. Spinal puncture immediately with a thorough drainage. A manometer may be used for this purpose and the pressure reduced one-half as recommended by Jackson, Fay and others. This is not essential at all and to decide for or against a decompression by a few points up or down a manometer gauge is rather hazardous. There is nothing more definite than observation of the patient himself.

The repetition of spinal punctures should be judged by the amount of blood in the spinal fluid, the rapidity of its diminution and the progress of the patient. Fay has recently shown that blood in the subarachnoid spaces temporarily and permanently damages the subarachnoid villi and the pacchionian bodies, the chief disposers of cerebrospinal fluid, causing pooling of the fluid, brain ischemia and later chronic external hydrocephalus and cerebral atrophy. Therefore, the blood is removed as rapidly as possible. Spinal puncture is used also post-operatively as brought out earlier in this paper.

- 3. Temperature, pulse and respiration are taken every fifteen minutes and any change is reported immediately.
- 4. Magnesium sulphate, one-half ounce, in one ounce water is given by mouth and repeated every four hours for twelve doses thereafter. If the patient is unconscious, this is given by rectal injections.

Occasionally, a rising pulse during this treatment may be controlled by glucose by vein as this replaces from the tissues the vascular fluid volume depleted by the magnesium sulphate. This should be given from the ampoules containing 50% solution and not in 500 to 1000 cc. of 5% of 10% as in this manner too much fluid is given and occasionally is followed by a very disturbing reaction. Not more than 300 cc. of fluid should be allowed each twenty-four hours and later the dehydration may be aided by substitution of sweetened or glucose drinks.

Antitetanic serum should not be given for several days or until possibility of operation is passed.

All such patients, according to the severity of the injury, should be kept in bed from thirty to ninety days without alcoholics or tobacco, restricted mental activity and not more than a 750 cc. fluid intake daily. In the more severe types, physical and mental activity should be limited for six to twelve months and the fluid intake should always be kept at a minimum—750 to 2000 cc. per day.

Even the slightest injury and change in character or mental condition, such as loss of memory or initiative, indifference, weakness, headaches or convulsive attacks, should call for a thorough study and ventriculography as many with conditions such as accumulation of blood or cerebrospinal fluid or air can be relieved by later operations.

It is only by a thorough understanding of what

is to be accomplished, prompt and conscientious treatment that we can lessen the mortality and morbidity of acute head injuries.

DISCUSSION

Dr. V. A. Lockwood, St. Augustine:

Dr. Van Schaick has given us such a comprehensive outline for treating fractures of the skull in so few words that it is difficult to add to his paper.

I am pleased that he has impressed upon us the necessity for a thorough examination for concurrent injuries. Recently two cases of head injury have come to my attention, one of which was a ruptured urethra and the other a ruptured bladder. Both of these injuries to the urinary tract needed more immediate attention than did the skull fracture. These injuries were diagnosed when an attempt at catheterization was made. Many patients who have sustained head injuries in automobile wrecks or any serious traumatism from other causes have ruptured bladders or abdominal viscera and if the patient is unconscious we are apt to overlook these concurrent injuries. Therefore, I believe that these patients should be routinely catheterized as soon as the patient has recovered from shock.

Dr. Van Schaick has given us a very conservative expression of the operative indications in depressed fractures. I agree with him that many of the slighter degrees of depressed fractures do not require elevation. This is particularly true if the depressions occur over the so-called silent areas of the brain. For example, we have seen persons who have sustained rather serious depressions in the frontal area who have never been operated upon and vet have recovered without any serious impairment. Therefore, I think we can very often dispense with the elevation of depressed fractures in these areas. However, when we have a depression overlying the motor area I believe that the fracture should be elevated as a subsequent paralysis or epilepsy may result.

I was glad to hear Dr. Van Schaick advocate spinal puncture as an adjunct in the treatment of fracture of the skull as this view differed from the opinions expressed yesterday at the meeting of the Association of Railway Surgeons. I do not believe that spinal punctures are necessary in those cases that show no manifestations of increased intracranial pressure. If the intracranial pressure is rising I believe that an attempt should be made to lower it with repeated spinal punctures

cautiously performed and with the various dehydration measures such as the use of magnesium sulphate per rectum and the intravenous injection of a hypertonic solution of sodium chloride administered with extreme slowness.

It seems to me that a number of communities in Florida cannot command the services of a neurological surgeon. Under these conditions our patients often stand a better chance if we will try these conservative measures before resorting to decompression operations which are best performed by those skilled in this particular field.

OCULAR DISTURBANCE IN PREGNANCY AND DURING THE PUERPERIUM* NELSON M. BLACK, M.D., Miami.

During pregnancy numerous changes are manifest in the eyes and their adnexa that are normal to the state and disappear with its termination. Not infrequently, however, disturbances of vision arise in the course of gestation and during the puerperium which are danger signals of the greatest importance. These visual disturbances may be the first indication of the gravest danger to the life of the woman, or the first symptoms of morbidity of the various ocular structures which may terminate in diminished vision or even blindness.

All the elements necessary for the growth of the foetus and for the promotion of its metabolic activity are derived from the maternal body, which also must take care of the waste products arising from the increasing cell activity. While the pregnant state is a physiologic condition, there is, nevertheless, an enormous demand on the reserve material of the maternal body. In addition, there is the mechanical interference with bodily functions due to pressure disturbance.

The increased demand on the reserve material of the pregnant woman is bound, under all circumstances, to diminish the resistance of the body to all injurious influences, autogenous or exogenous. Thus, in any organ of the body in which there exists some abnormality, or in which there is present, at the time of conception, some morbid process, the chances for pathologic changes to take place or to increase are greatly enhanced by the generally lowered bodily resistance. Further, the general lowered resistance cannot successfully

^{*}Read before Staff meeting of St. Francis Hospital, Miami Beach, March, 1931.

combat the malign effects of a focus or foci of infection that may be active in the body; these, indeed, may be the exciting factors in lighting up morbid processes in any organ, the eye not excepted.

The early recognition of ocular disturbances during gestation is of great importance, as they frequently are danger signals of marked systemic changes that menace not only the eyesight of the woman, but possibly her life.

Increased deposit of pigment in the rete mucosum of the lids, as well as in other parts of the body, is frequently noticed. These chloasmata uterina consequent on the destruction of a large number of red blood corpuscles usually disappear after delivery, depending on the depth and extent of the pigmentation. In patients with marked chloasmata, examination of the blood is indicated as well as determination as to whether activity of the kidneys is diminished.

Any previously existing weakness of the intrinsic and extrinsic ocular muscles may be aggravated, especially if the general physical condition has become below par as the result of nausea and vomiting.

Polyopia may develop in the early months, and is usually one of the manifestations of an hysterical condition. Yet hysteria should be the last condition thought of in any case of pregnancy.

External and internal squint is occasionally present, especially in those with unstable muscle balance, and is most difficult to relieve, owing to the irregularity of the manifestations of the strabismus.

Occasionally, the secretion of tears is increased from the third month on to term, and is quite annoying. This is frequently accompanied by increased secretion from the salivary glands. Usually, in these cases, the lacrimal and salivary glands are swollen.

Subconjunctival hemorrhages occasionally occur. If frequent and large in amount they indicate some cardiovascular change, and should be regarded as a danger signal. They may be early signs of a grave toxemia.

The phlyctenular inflammations of cornea and conjunctiva which occasionally occur during pregnancy are not peculiar to the condition and will not be dwelt on. Ulcers of the cornea are not frequent in pregnancy, but develop from the usual causes, i. e., injury and infection. Softening of the cornea, keratomalacia, occasionally develops in subjects very much enfeebled by pernicious vomiting and dyscrasias. Conical cornea is said

to have developed in pregnancy, and to have its origin during the stress of delivery.

As a result of reflex disturbance through the sympathetic nervous system, miosis or mydriasis may be in evidence. Cycloplegia may appear during the latter half of pregnancy, the result of insufficient enervation of accommodation, and is most annoying.

Intercurrent iritis or cyclitis is dependent on preexisting causes, systemic infections or toxemias generated by the pregnant state.

The formation of cataract has always been considered as due to preexisting disease.

Vitreous hemorrhages occur frequently, causing great alarm. As a rule, however, there is complete absorption with no loss of vision.

Bitemporal contraction of the visual fields with enlargement of the blind spot of Mariotte has been observed in pregnant women by various writers for many years. The consensus of opinion formerly was that these symptoms in individuals with otherwise normal eyes were the result of a normal physiologic hypertrophy of the pituitary gland in the pregnant woman, producing compression of the chiasm which manifests itself by changes in the visual fields. The changes vary in degree and amount according to the degree of compression suffered which depends upon the amount of hypertrophy and on the anatomic peculiarities of the individual skull, which might favor or hinder compression.

Dr. Juanita P. Johns' conclusions, after very thorough examinations of 29 young women who presented initially the usual evidences of normal uncomplicated pregnancy are as follows:

- "(1) The investigation showed definite concentric contraction of form and color fields in the majority of the cases.
- "(2) The blind spot showed enlargement in the majority of the cases.
- "(3) Enlargement of the blind spot and concentric contraction of the form and color fields are consistent with a general reduction of retinal vitality, in that the parts of the field involved in the contraction are those having a minimum retinal sensitivity. The endocrine studies show a lowered vitality through the pregnant state, tending to return to normal post partum. This parallels the visual field studies in this series of cases.
- "(4) These visual field studies do not show the characteristics of pathology of the pituitary gland associated with enlargement great enough to cause pressure, such as bitemporal hemianopsia, superior temporal cutting, scotomata in the cecocen-

tral of paracentral area, or interlacing of color fields. These measurements are apparently not of sufficient magnitude to have arisen from either pressure or contact.

"(5) On the basis of the visual fields, the radiographic measurements, and the investigations of vital function, it seems warrantable to conclude that the field changes in pregnancy probably depend upon functional modification rather than upon enlargement or vascular changes in the pituitary gland. Whether these field changes are to be regarded as physiological or pathological is a question, only to be decided by further study."

RETINITIS AND NEPHRITIS

The neuro-retinal disturbances liable to complicate pregnancy are classified by Woods as: "(1) The sudden amaurosis usually called uremic: (2) The retinal changes spoken of as albuminuric retinitis of pregnancy; (3) Loss of vision in some parts of the visual field without retinal lesion, sometimes with pallor of the disk, and (4) Neuro-retinitis not resembling that called albuminuric.

"It is now accepted that the eclampsia of pregnancy is not uremic in origin but is allied to pernicious vomiting which is caused by the circulation of toxic substances in the blood." So the amaurosis of eclampsia is believed to be due to a sudden toxic saturation of the optic nerve and retina, retinal changes being absent because of insufficient time for them to develop. This view is supported by the fact that optic atrophy sometimes follows uremic amaurosis.

The term albuminuric retinitis of pregnancy has been superceded by retinitis of pregnancy. "So far as they occur together, retinitis of pregnancy and albuminuria may be disassociated, for it is a patent fact that either may and frequently does exist without the other. Therefore, an albumin-free urine need not rule out a diagnosis of toxic retinitis in a pregnant woman."

Retinitis of pregnancy is a rare occurrence, being found, according to Silex, but once in from 3,000 to 4,000 pregnancies; while albuminuria during gestation is not uncommon, varying from 2 to 20 per cent. (And retinitis is found in albuminuria once in forty-five cases).

The retinal disturbance is not considered to be a form of albuminuric retinitis although the true retinitis may develop during pregnancy from a preexisting chronic nephritis; nor is the nephritis of pregnancy a true inflammation. Both the retinitis and nephritis are undoubtedly dependent on the same cause, a toxemia. What the nature of this poison is has not been fully settled, but

progress has been made. At least a name has been attached to the toxins, viz., synctiotoxins. Formerly these were thought to be the products of the disintegration of the syncytial cells. Below this is Langerhan's layer, composed of low cuboidal cells; the function of this layer is not understood. Later in pregnancy the Langerhan's layer entirely disappears, but the syncytium does not degenerate nor break up, but is present in the placenta at term.

The present theory, brought out about two years ago, is that the foetus always develops these toxins, but under ordinary conditions they are held back by the syncytium and consequently do not reach the maternal circulation. Occasionally, for some unexplained reason, the syncytium becomes permeable for these toxins allowing absorption, with the resulting toxemia. The origin and function of these cells are physiologic; and when their purpose is served, their death is likewise. One might say the formation of toxins in one's body is a physiologic process. It is not the formation, but the failure of proper elimination of toxins, which acts deleteriously on the economy.

The ophthalmoscopic signs of the retinitis may not differ from those associated with other forms of nephritis. In general terms, there is a widespread neuroretinitis with exudate and hemorhage. The retinitis is toxic rather than vascular in origin, although gross endarteritis with obliteration in the choroidal vessels and in the posterior ciliary as well as the retinal vessels has been found. The findings in the majority of cases have been such as to allow us reasonably to suppose that the vascular changes that take place in pregnancy and in the nephritis of pregnancy are of a temporary nature. Perhaps in half of the eclamptic cases, the patients complain of disturbances of vision, but decidedly few will show evidences of retinitis, and among these the star figures are rarely found.

In the retinitis of pregnancy, the prognosis, so far as it concerns the vision and the life of the patient, depends on the duration of the gestation. If the visual disturbances occur during the first six months, usually the pregnancy should be terminated if the sight is to be saved. Also, it must be borne in mind that any serious eye lesions may be made worse by a subsequent pregnancy.

Chronic nephritis and the retinitis caused by it form sufficient indications for the termination of the pregnancy, as the patient may recover from the nephritis, or at least be greatly improved. The induction of labor, therefore, has been recommended as a therapeutic measure, because with the termination of pregnancy the inflammatory deposits in the retina may be absorbed and good vision be restored, provided the process has not continued so long that secondary changes have taken place.

In general, it may be said that retinal hemorrhages usually indicate a grave toxemia.

If, when the hemorrhages are over the macula, and the optic nerve is involved, the symptoms are not heeded, during which time the toxemia becomes increased, a permanent impairment of vision is inevitable. The life, future health and vision of the woman are, therefore, best safeguarded by an interruption of the pregnancy. Usually, the vision improves rapidly after delivery, and the exudation and hemorrhages become absorbed to a large extent, although in extensive effusions a certain amount of permanent impairment of vision is usual.

The prognosis as regards sight in these cases is probably not so good as is commonly thought, though as regards life it is much better than in the nephritis of the nonpregnant. Sight, however, never improves until the pregnancy is terminated. Without the induction of labor, the prognosis is most serious. Cases which go on to term show the greatest proportion (16 per cent) of deaths, and the greatest damage to sight. Spontaneous premature delivery shows 11 per cent of deaths, while after the artificial delivery, the mortality is but 4 per cent.

Silex found a return to normal vision in only three cases out of thirty-five. Therefore, only moderate vision can be anticipated if labor is induced at the seventh or eighth month of pregnancy. Accordingly, in the last two months, ocular symptoms are to be weighed with other findings. Usually, partial optic nerve atrophy is present with white or pigmented spots at the macula. Fortunately, recovery follows in the majority of cases in which visual disturbances have not come on until the last two or three weeks.

A true optic neuritis is not infrequently found associated with the toxemia of pregnancy. In such instances, the relations of the optic nerves to the pituitary body must not be overlooked, and because that structure is so frequently affected in the course of pregnancy, it should be borne in mind that pressure on the nerve may arrive from swelling of the hypophysis.

DETACHMENT OF RETINA

Detachment of the retina is one of the unusual ocular complications of pregnancy and of the pucrperium, arising from the strain of prolonged and difficult labor; it occurs more frequently in the course of retinitis of the pregnant than in the retinitis of the nonpregnant woman. In certain of the cases reported, myopia had already existed, a condition that should always be considered as well as the effects of the puerperium, because stress in the susceptible can be sufficient to cause detachment. Bilateral detachment of the retina has occurred, but in practically every case the membrances became reattached, although retinal atrophy supervened.

From the cases reported, the chances of recovery of perfect vision after detachment of the retina during pregnancy, labor or in the puerperium seem to be better than in the nonpuerperal state. The induction of labor, therefore, may favor the reattachment.

EMBOLISM OF RETINAL ARTERY

It is well known that distinct modification of the cardiovascular system occurs during pregnancy, and that the constituents of the blood are changed, comprising an initial reduction followed by increase in amount of fibrous elements; and it is marked by variations in the blood pressure during the last three months. Numerous cases of what has been considered to be embolism of the central artery have been reported, for which affection no other cause than the general blood changes could be assigned. Merely a branch, as the superior temporal, may become affected so that only the portions above the macula become ischemic with the consequent defects in the lower portions of the field and a reduction of the general visual acuity. The value of the cilioretinal vessels in supplying the ischemic area is here fully shown. Occasionally, the vision may be largely regained owing to the restoration of the lumen of the vessels involved.

OBSERVATIONS AT CHRISTIANIA CLINIC

In the Christiania Clinic, eye examinations were made by Schiotz on all pregnant patients with subjective eye disturbances, on those with pregnant toxicosis and on most patients who showed more than ordinary confinement albumin. During five years 680 patients were examined; 158 cases of eclampsia occurred during that time. Among his patients with no albumin and no symptoms of intoxication were found two cases of hemorrhage into the vitreous, one of embolism of a branch of the central artery, one of recrudescence of old chorioretinitis, one of keratitis superficialis, one of keratitis disciformis, two of retinal detachment

in excessive myopia, three with old fundus changes, one of transitory myopia during pregnancy, and two of retrobulbar neuritis in hyperemesis gravidarum. Forty cases of pregnancy retinitis were observed; of these, ten patients had chronic nephritis before, and after pregnancy; seventeen were healthy before, but showed nephritis after the pregnancy; six were free of symptoms before and after pregnancy, and in seven, the follow-up examination was missing, or the retinitis was not healed at the time of the report. Retinitis was found sixteen times in primiparas, and twenty-four in multiparas. The retinitis usually began in the second half of the pregnancy. Of the forty patients, fourteen had, in follow-up examinations, normal vision; all others, with the exception of one who was totally blind, had vision sufficient for work and for reading. The good vision is due to the active treatment, especially to the induction of labor. Most patients had nephritic symptoms before the pregnancy, while some seemed to have developed a chronic nephritis in consequence of the pregnancy kidney. In six cases, a pure pregnancy kidney seemed to have existed, the patients having no symptoms before or after the pregnancy; four of these patients subsequently became pregnant again.

EYE SYMPTOMS WITH ECLAMPSIA

Of the 132 patients with eclampsia, and twenty-six with threatening eclampsia, twenty-seven showed retinitis or papilloretinitis, four, complicated with detachment; one showed hemorrhagic retinitis, and three, detachment without retinitis; in two patients papillitis, in two edema of the retina, and in three chromatopsia was noticed. In all, 33 per cent of the patients showed eye symptoms. During follow-up examination of twenty eclamptic patients, all were found perfectly well, free of albumin and with normal blood pressure. This contrasts greatly with the pregnancy retinitis cases; thirteen of these patients subsequently became pregnant.

FOCAL INFECTION

Since foci of infection in the paranasal sinuses, teeth and tonsils are considered to be such active factors in the etiology of ocular disorders in apparently healthy persons, it is only reasonable to suppose that they would be increasingly dangerous as etiologic factors in the condition of lowered bodily resistance such as that induced by pregnancy.

Four cases of neuroretinitis of pregnancy with marked albuminuria and marked reduction of vision have come under my observation. In each case, extremely active infectious processes in the teeth and tonsils were found. Unfortunately the damage to the eyes had already occurred, but improvement in the ocular condition, which in two cases was marked, and in the other two slight, did not take place until treatment was directed to the infected teeth and tonsils.

Would it not be wise, therefore, during gestation, in addition to the early frequent examinations of urine which is practically always done, also to search for possible foci of infection, especially in the teeth, paranasal sinuses and tonsils, and correct, if possible, morbid processes when found, rather than to run the risk of allowing the patient to proceed to term with the possibility of having to terminate the pregnancy in order to save life or preserve vision?

It is also suggested that visual examination should be made, as a routine procedure, during the latter months of pregnancy, with especial regard to the fundus and visual fields.

UNUSUAL ULCERATIVE CONDITION OF THE CHEST WALL. DIAGNOSIS:

TUBERCULOUS GUMMAS*

(A Clinical case with lantern slides)
J. LEE KIRBY-SMITH, M.D., Sc.D.,
Jacksonville.

This paper is a report of unusual subdermal abscesses of the chest wall, of an apparently healthy individual, extending over a period of two years, in which a clinical diagnosis of tuberculosis cutis is made. From the facts of the case as obtained from repeated examinations, the diseased processes are primary, and not secondary to any lung pathology. Accordingly, the writer presents an unusual case of erythema induratum-tuberculosis indurativa, i. e., tuberculous gunmas.

Patient Garcia, referred by Dr. J. K. Norwood of Jacksonville for diagnosis and treatment, June 2, 1930, gave the following history: Male, age 32, native of Cuba and cigar-maker by trade, he came to this country at the age of sixteen. His family history gives nothing of value. He had the usual childhood diseases, including diphtheria and scarlet fever. No history of venereal disease. At three years of age he had a perineal fistula which was cured by an operation. The only disabling sickness that could be elicited was articular rheumatism of four months' duration which occurred nine years ago, and since that time the patient has pursued his occupation without loss

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

of one day on account of illness. The patient has been married seven years. There are no children.

The history of the present illness began two years ago. A subdermal abscess developed in the chest wall below the left nipple. This was drained and later excised by Dr. Norwood. Cultures from the pus showed staphylococcus aureus present. Other abscesses formed from time to time that were drained and underwent slow healing processes, but were for the most part active. Autogenous vaccines were made and used along with injections of manganese butyrate with no results. A complete physical examination and X-ray study of the chest wall (Drs. Cunningham and Shaw) showed nothing of importance.

On the first examination of the case the patient had a number of subdermal abscesses with sinuses, discharging odorous, thick, greenish pus; one or two scars of previous lesions, one of which had been excised six months before. There had been eighteen lesions in all. The following is a detailed account of various laboratory procedures undertaken to obtain a diagnosis, and therapeutical measures for treatment of the disease.

A tentative clinical diagnosis of syphilis was made, this in spite of three negative serological tests taken during the preceding six months. However, after three provocative tests, June 2d, 6th and 10th, using 0.6 gram neoarsphenamine with no noticeable improvement, syphilis as a diagnosis for the time being was omitted from consideration. This opinion at a later date was further emphasized by intensive treatment with large doses of iodide of potash, and additionally a series of intramuscular injections of bismuth salicylate, with no noticeable improvement in the character and occurrence of active lesions.

Next in order was a consideration of possible mycotic fungi infection; actinomycosis or sporotrichosis, etc. An effort was made on several occasions to get a growth on different culture media by ordinary methods and one suggested by Ashford of using the expressed serum from a fresh biopsy. This was done by Dr. C. E. Royce, pathologist, St. Vincent's Hospital, Jacksonville. Cultures and smears were taken for Dr. Paul Eaton, director of the Florida State Board of Health Laboratory, June 2, 1930; cultures on usual media and on Sabauraud media for mycotic fungi. Both of these laboratories reported no growth. In addition to culturing, repeated examinations of fresh pus smears failed to show any mycelia or spores of fungi. Dr. Eaton reported no bacteria from fresh pus, on four separate slides using various staining methods.

June 2, 1930. X-ray and potassium iodide treatment instituted. Within two weeks' time improvement noted.



Illustration No. 1. Photograph June, 1930, showing location of lesions.

June 23. Von Pirquet tuberculin test on one arm. In twenty-four hours beginning erythema. Same tests on the other arm. A week later there was a marked reaction. (One still present on Aug. 29, 1930). Today, May 11, 1931, there is a raised erythematous papule at the site of the innoculation.

July 15. Complete X-ray study of chest and chest wall reported negative. (Same had been done eight months previous).

July 18. Biopsy of active lesion, and cultured again on Sabauraud media for Dr. Royce. All reported negative. Dr. Royce's report on biopsy was very incomplete. No details as to pathology given. (Report received Sept. 3). Two skin units of X-ray filtered (MacKee formula), one-third dose to each sinus once a week for six treatments.

Aug. 29. All old lesions apparently well except one. On this day two new foci opened, and drained purulent pus. These lesions in the open, three inches below the nipple (right), had been coming on for two weeks as inflamed, indurated

areas having the appearance of subcutaneous abscesses.

Sept. and Oct. Chest wall treated with air-cooled ultraviolet ray. Two new abscesses formed. Old ones gradually healed up.

Nov. and Dec. Intramuscular injection of bismuth at five-day intervals. Discontinued iodide of potash. Since Dec. 15, one new abscess formed, opened and drained.

Jan. 5, 1931. There were three slightly active foci discharging very slightly. On removal of scabs there was apparent a small crater formed sinus. Very slight discharge. The general health of the patient good. Serological reactions negative.

Jan. 10. Biopsy of new lesion and pus smears sent to Dr. D. L. Satenstein, dermatopathologist for the department of dermatology, New York Post-Graduate Hospital. Bismuth, ultraviolet ray.

Jan. 20. Kahn test negative. Four pus smears for State Board of Health. Opened two new abscesses. Ordered potassium iodide after four weeks' intermission. Note: When taking KI shows improvement. Ultraviolet ray.

March 18. Urinalysis negative. Complete blood study by Dr. Kirk, Jacksonville, negative. Kahn tests, (two) negative, making eight tests. Third Roentgen study by Dr. Cunningham, negative. The patient had new abscesses forming on this date.

March 19. Von Pirquet test positive. Another biopsy sent to Dr. Royce for guinea pig inoculation. Reported no tuberculosis found, May 11, 1931.

March 27. Biopsy sent to Dr. Fred D. Weidman, dermatological research, University of Pennsylvania. Reported negative.

April 21. Intravenous injection of gold sodium thiosulphate, 0.5 gram (Triphal), repeated at seven-day intervals. Last treatment May 8. Improvement noted after second treatment.

May 11. There are five slightly discharging abscesses.

With this situation, excluding syphilis and mycotic disease, the only possible pathological condition that could be definitely considered is tuberculosis of the skin. To substantiate this diagnosis a clinical one is more valuable and especially by definite exclusion of the two preceding conditions. A histo-pathological confirmation would be desired. Accordingly in the past year three separate biopsies have been performed

and submitted to competent pathologists for study, but no clear-cut definite tuberculosis process is reported. No tubercule is recognized, nevertheless, according to most authorities this failure will not exclude tuberculosis. Cutaneous tuberculin tests, the Von Pirquet, were, as mentioned, strongly positive. Guinea pig inoculation by Dr. Royce, negative for tuberculosis.

SUMMARY

No. 1. Four Von Pirquet tests strongly positive.

No. 2. Three X-ray studies of the chest throughout negative.

No. 3. Thorough examinations by internists negative.

No. 4. Three provocative Kahn tests negative (0.6 neo-ars.).

No. 5. All cultures negative for mycotic fungi. No. 6. Urinalysis negative.

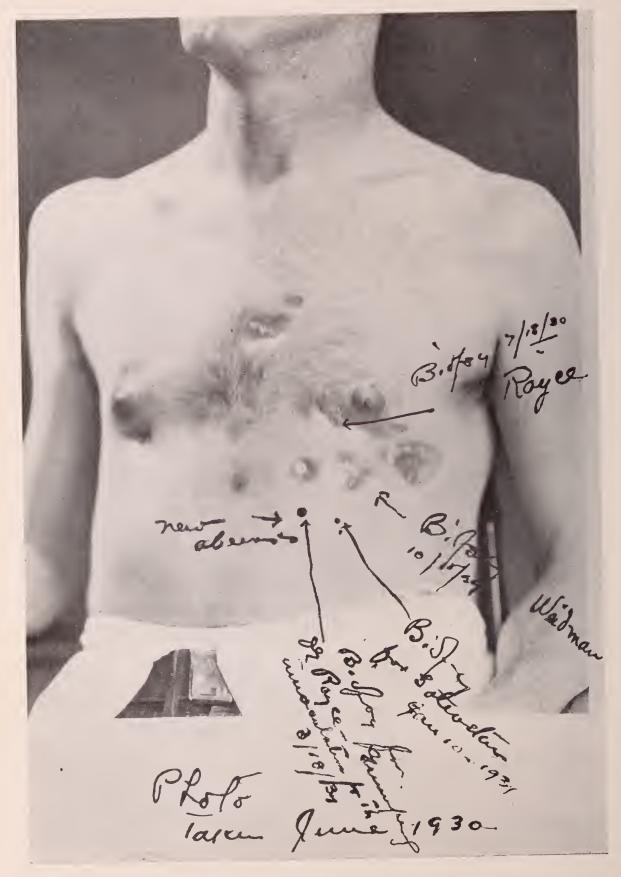
Xo. 7. Complete blood study negative (Dr. Kirk).

No. 8. Three biopsies negative for tuberculosis.

No. 9. Ten Kahn reactions negative.

In the matter of importance and the frequency of occurrence the clinical manifestations of tuberculosis of the skin could be enumerated as follows: Lupus vulgaris, tuberculosis cutis orificialis, tuberculosis verrucosa cutis, scrofuloderma and tuberculous gummata which is the variety under discussion. In the writer's experience all forms of tuberculosis of the skin are extremely rare in Florida. In the practice of twenty-one years devoted exclusively to the treatment of skin diseases, hardly one-half dozen cases of tuberculosis of the skin have been seen. Our bright sunlight and equitable climate are both antagonistic to the bacillus tuberculosis; whereas, in our large northern cities, and especially in Europe, tuberculosis of the skin is not infrequently encountered.

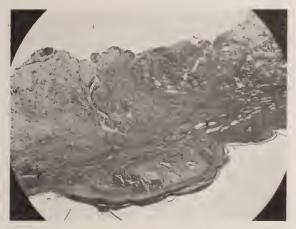
To the general medical man, the type of tuberculosis of the skin with which he is most frequently associated in his practice, would be the scrofuloderma type. In this type, skin ulceration is a secondary one, due to the invasion of the skin by the bacteria from a broken-down lymphatic gland or other focus of infection. Next, no doubt, would be tuberculosis cutis orificialis. This condition is somewhat analogous to the preceding, i.e., a secondary ulceration of the skin of the muco-cutaneous parts at the orifices of the body, as nose or annus, and from some tuberculous process in the body. In other words, the two pre-



Same as No. 1, showing location of biopsies.

ceding clinical varieties are secondary tuberculosis.

The case that is presented today, as was said in the preface, is classified as primary tuberculosis of the skin, tuberculosis indurativa, or tuberculous gummas. This variety is unquestionably rare, and not without some uneasiness does the writer adopt this classification for the unusual



Low power shows thinning of epidermis and loss of rete pegs and general infiltrative nature of the lesion.

skin ulceration, and only after three complete X-ray studies of the chest, and several examinations by competent internists. Then, too, from the fact that the patient has been observed twice a week for a year, and as previously mentioned, from a complete lack of lung pathology.

A thorough search of all available literature in the New York Academy of Medicine gives very limited reports on the occurrence of this clinical variety of tuberculosis of the skin other than on the limbs of young women. Nevertheless, V. Mucha¹ calls attention to four clinical cases of erythema induratum that occurred on the chest and upper limbs. This writer gives a complete review of the subject.

Sutton² devotes a paragraph under the heading of Tuberculous Gummata, and has this to say:

"Tuberculous Gummata are subcutaneous tuberculous lesions which develop independently of demonstrable lymphnodes. Ultimately, the integument over the entire mass breaks down and an ulcer is formed. The condition is probably identical with the 'tuberculous lymphangitis' of Bazin."

Under the title "nodular tuberculosis of the hypoderm", Wende has described an unusual form of tuberculosis of the skin characterized by the occurrence of painless, subcutaneous nodules which vary in size from that of a pea to that of an English walnut, and which break down and ulcerate. The chin, cheek and temples were involved in Wende's case. The overlying epidermis was normal in color. A few of the lesions underwent spontaneous involution. Histologically, the tumors were tuberculous in character. Animal inoculations proved positive. In some respects the lesions resembled the so-called "sarcoids of Darier-Roussy."

In the matter of the diagnosis of tuberculosis of the skin, one has to rely on a clinical diagnosis. To quote Satenstein3 in a recent article, "To establish a histologic diagnosis of any one of the many clinical forms of tuberculosis of the skin, the tubercle must be present. When the tubercle is absent, other fields of investigation, such as the bacteriologic, serologic, and biologic, must be employed to arrive at a diagnosis. When the tubercle is present, these methods should be employed to substantiate the histological diagnosis." But for various reasons it is an established fact that the tubercle, though present, is very difficult, indeed, to locate.

In the matter of treatment of the case presented today, you will have gathered that during



Low magnification shows edema, thinning of epidermis and general infiltration.

the past year all possible measures at one's command have been used to cure this disease. Each remedy used has for a time seemed to produce some curative result, but, at this writing, the patient still has a number of active lesions.

In closing the report, the following summary is submitted. An atypical, chronic, subdermal abscess formation of two years' duration in an apparently healthy individual. By clinical exclusion, and resorting to the most thorough and complete laboratory facilities in the country, a

diagnosis is made of an unusual type of tuberculosis of the skin.

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 23-2.

DISCUSSION

Dr. C. A. Andrews, Tampa:

Dr. Kirby-Smith has presented a most unusual case. I first saw this case last summer, at a meeting of the State Dermatological Society, and at that time Dr. Kirby-Smith remarked that he could not recall seeing any condition similar to it in his experience. The dermatologists familiar with this case, appreciate the real work he has done to arrive at a diagnosis.

In looking over the literature at my command, I find that the term "tuberculosis cutis" is used quite broadly for all skin diseases known to be caused by the tubercle bacillus, and that this heading has quite a number of subdivisions which apparently overlap, according to some writers in their case reports presented to the various dermatological societies.

Cases discussed have the same difficulty that Dr. Kirby-Smith has encountered, namely, laboratory facilities, in that it is often difficult to have histo-pathological findings substantiate the clinical findings, and, even after arriving at the diagnosis, tuberculosis cutis, to properly place the particular case at hand, in one of the localized forms of skin tuberculosis.

Personally, I feel that I agree with the diagnosis, though I have never seen a case of Bazin's disease in any other location except the classical picture, viz., on the calf on the lower part of the leg; however, several texts state that it may occur on the arms or elsewhere.

Dr. Kirby-Smith has definitely ruled out, to my satisfaction, fungus diseases, syphilis and cancer, drug rashes of the iodides and bromides, and the condition cannot be of the scrofuloderma, because it is primary, and scrofuloderma is always secondary.

Lowenstein, a number of years ago, stated that "the skin may acquire a predisposition to tuberculosis if the infection occurs in it. Tuberculosis of the skin is rarely associated with a progressive tubercular infection of other organs."

The essayist has not been able to find any evidence of tuberculosis elsewhere in this case.

At this point, however, I want to give the de-

ductions of the Third Congress of French-speaking Dermatologists. It was stated that tuberculosis of the skin was only an expression of general tuberculosis, and demanded general treatment.

I think in discussing this paper one should stress the rarity of tuberculosis of the skin in Florida. In my experience I have seen only four cases in Tampa. This does not of course include lupus erythematosis, which is still a disease of unconfirmed tuberculous etiology.

In the treatment of tuberculosis of the skin so many methods have been used, for local applications, that it is hard to recommend any single one that stands out. Ultraviolet therapy is excellent; however, the Finsen light should be more ideal, since it has more penetration.

In the last few years the gold preparations, intravenously, have been commented on most favorably. Tuberculin has its supporters, but both should be used carefully and cautiously.

Abroad, the salt-free diet, first described by Gerson, and varied by Sauerbruch and Herrmanndorfer, at the present time is apparently quite popular. Briefly, this diet eliminates the use of salt in the preparation of food. Meat is given sparingly or not at all, and all foods are rich in fats, but deficient in carbohydrates. To provide for vitamines plenty of fresh fruit and vegetables are given, fat from unsalted butter, and milk and milk gruels.

An attempt is made to have the patient take food at least seven times daily. Cod liver oil is given twice daily. It is found that by the addition of phosphorus, the patient does better than with plain cod liver oil.

In addition the light treatment, sunlight as well as ultraviolet rays, is a valuable adjunct. Many reports have shown remarkable results with this method of treatment in tuberculosis of the skin, but enough time has not elapsed to properly evaluate this method.

In conclusion, I wish to state that I have enjoyed the paper of Dr. Kirby-Smith and feel that he has properly classified this unusual skin condition.

Dr. J. Frank Wilson, Jacksonville:

This is one of the most unusual cases I have ever seen. I have followed it rather closely for the past year, having seen it once or twice a month during that time. It is a most baffling case from every standpoint, both as to diagnosis and treatment. I have made and discarded one diagnosis after another and finally through a process of

elimination have reluctantly agreed that it must be primary tuberculosis of the skin. I have never seen a case of tuberculosis of the chest wall without involvement of the deeper structure, but repeated X-ray examinations seem to eliminate any disease of the lungs or ribs. Laboratory work was done by some of the best men in the United States and all their findings were completely negative. It seems reasonable to suppose that with these thorough examinations that the causative factor would have been found unless it is tuberculosis for it is almost impossible to diagnose tuberculosis of the skin by laboratory methods.

Tuberculosis of the skin is extremely rare in Florida. I have thought once or twice that I had seen a case but it always proved to be something else. Only recently I saw a case that was elinically identical except for the location which happened to be over the ischio-sacral articulation, but as the lesions healed when thoroughly cauterized and have not returned in two months they were probably not tuberculous.

In the case under discussion, the lesions first appear as abscesses and seem to be firmly attached to the bony structure beneath. Upon being opened there were sinuses extending deep into the tissues; in some cases as much as two inches, but after healing these tracks disappeared and the sears are freely moveable showing no connection to the ribs at all.

I am still slightly dubious about the diagnosis. Potassium iodide should not be of benefit in tuberculosis but seems to help this case. Gold sodium thiosulphate should be of benefit and apparently it was for a while, but after several weeks' treatment the patient recently returned with five new lesions.

I consider myself fortunate to have seen the case and to have been allowed to discuss it. The amount of work done by Dr. Kirby-Smith has been prodigious and the case excellently presented.

Dr. J. L. Kirby-Smith, Jacksonville (concluding):

I had hoped that Dr. Royce, who is present today, would have been allowed to discuss this case, as he is familiar with the difficulties encountered in confirming the clinical diagnosis.

I think that sometimes we become discouraged with the help and cooperation that we get from the laboratory. We should not, though. They merely report what they see and we take their report and incorporate it in our diagnosis. Such has been the case of the writer, and I assure you

that he has employed the best laboratory facilities available.

The case that I presented today is unquestionably unusual and, no doubt, tuberculosis of the skin. The point that I have emphasized is, so far as can be ascertained, that the lungs and chest are negative for disease, and such being the case, the scrofuloderma type of tuberculosis of the skin would be left out of consideration. Accordingly, the inflammatory abscessed processes breaking down would be classified as tuberculous gummas. The various measures and treatments that were enumerated were carefully carried out and, the patient was under constant observation. Today the patient has five lesions present.

In regard to the remarks of Dr. Andrews about lupus erythematosis, we do not consider this condition now-a-days as being related to tuberculosis as such was the case several years ago. It is generally considered that the skin condition is due to some focal infection, plus external irritants.

In Florida, lupus erythematosis is quite often encountered. The bright sunlight seems to stimulate this chronic inflammatory process. These patients are usually considered as photo-sensitive.

In concluding, I would state that it is my experience that tuberculosis very infrequently originates in our state, and especially rare is tuberculous manifestation of the skin. Our clear sunshiny climate is prohibitive.

I thank you very much.

SOME PROBLEMS IN UROLOGIC DIAGNOSIS*

W. Houston Toulson, M.D., Baltimore, Maryland.

Kidney infections illustrate very well many of the difficulties in urologic diagnosis. Most infections of the kidney pelvis promptly invade the kidney tissue giving rise to pyelonephritis. This occurs in such varying degrees that it is impossible to estimate the kidney damage, although some idea of renal impairment is obtained by the phthalein test of the two kidneys. This invasion of the nephritic substance also explains why a chronic infection is so difficult to clear up. These cases of pyelonephritis have an entirely different elinical picture from such intrinsic kidney inflammations as acute nephritis or Bright's disease and have entirely different urinalyses. For example, in pyelonephritis there is relatively less albumin and fewer casts than in nephritis. Periodically

^{*}Read before the Dade County Medical Society, Miami, February 6, 1931.

there is a negative urine in pyelonephritis especially in those cases where the urine is trapped.

In the acute cases pyelonephritis is occasionally ushered in with chills when it is often mistaken for influenza. The chronic types often have pronounced symptoms of nausea, vomiting, diarrhea, constipation, abdominal distention and generalized abdominal pain, especially when there is a poor kidney function. These symptoms influence an incorrect diagnosis of lesions in the stomach or intestine. On the other hand, it is astonishing how much kidney damage can occur with so few symptoms. The distinguishing feature in the diagnosis lies in carefully repeated urinalyses.

The bacterial invaders in most of these cases are the b. coli, staphylococci aureus and albus, streptococci and pyoceaneous, occasionally the pneumococcus and very rarely the gonococcus. The b. coli usually overgrows the other infecting organisms in culture and occasionally masks an acid fast infection. B. coli infections at times give rise clinically to a bradycardia and leucopenia; this is probably explained by the fact that the organism belongs to the typhoid group.

The cause of these renal infections is not always clear. Ascending, hematogenous and lymphatic avenues have all been discussed elsewhere. There can be no conception of infections in the upper urinary tract without consideration of the adnexal glandular structures and of the conditions that go hand in hand with infections, namely calculus formations and other common urinary obstructions, as urethral strictures and ureteral strictures, diverticulations of the bladder, aberrant renal blood vessels, abdominal tumors and anomalies of the kidneys and ureters, all of which favor stasis and infection. These conditions have to be recognized and treated before the secondary pathology can be cured.

There are many things in the adnexal structures, as the prostate and seminal vesicles, to be considered before going to the teeth, tonsils, sinuses, etc. On the other hand, it has been shown that prostatitis and seminal vesiculation may be secondary to infections outside the urinary tract.

The gall-bladder and appendix may also cause confusing conditions in the urinary tract. Recently in the University Hospital in Baltimore there have been three cases of persistent right-sided pyuria with normal appearing pyelograms. These patients all had pain in the right lower quadrant, in each instance there was a postcaecal appendicitis; the tip of the appendix was attached to the peritoneum immediately overlying the

ureter. The pyuria cleared following an appendectomy. Apparently then, it is possible to err on the side of neglecting an inflamed appendix in dealing with urinary infections. Where there is any doubt the appendix had better be removed.

There is one very common condition that gives rise to so many vague and sometimes distressing symptoms that it is a good practice to rule it out before considering upper urinary tract pathology and that condition is verumontanitis. In my experience this condition may mimic the symptoms of almost any urological condition. The frequency and urgency and at times hematuria resembles a tuberculous infection so much that it seems that the acid fast organism must be found. The veru in these cases is so enlarged from inflammatory edema that it almost completely blocks the urethra.

Keyes says, "Quite frequently I see in consultation, patients with kidneys and prostate inflamed who have been vainly treated for months and yet need only a few massages of prostate and seminal vesicles with a whispered word of advice on sex to cure them."

In spite of the propaganda that urologists have tried to spread we still see too few children with pyelonephritis. Fortunately, most of these cases clear up with proper medication but when you consider the frequency of urinary infections in children it is unlikely that the chronic cases, especially, escape damaged kidneys, which might be improved by proper drainage and by the recognition and removal of the cause of the pathology.

Where there is a disturbance of the contour of the kidney pelvis pyelograms will usually demonstrate the condition, but even this is not easy of interpretation in early pathology, since there are so many variations of the normal pelvis, not to mention technical errors of a poorly filled pelvis.

It is manifestly unfair to the roentgenologist to expect him to be able to make a diagnosis from the appearance of a few, and sometimes one, film when the urologist who has all the clinical data at his disposal is often confused.

With the advent of the idea of intravenous pyelography impressions of urinary tract both physiology and pathology should be better understood as its use becomes more general. Already its advantages are seen, if not in demonstrating the pathology at least it gives an idea which may be brought out in sharper detail by an injected urogram. Gross changes, however, such as ptosis, hydronephrosis and anomalies should be identified ordinarily and in any cases where there

is urinary stasis. In children and in cases difficult or impossible to cystoscope its use will be invaluable. Already there are indications that the dose of these agents for intravenous use will be smaller and the delineation of the shadows in the X-ray be better.

At best, as we have seen, pyelographic interpretation will lead us far astray in our diagnosis unless it be correlated with the other data. One of the most signal advances in diagnosis has been the application of moving pictures to pyelograms. This work is being done by Cumming of Detroit. It means that instead of having to base a diagnosis on one pyelogram, which, as has been said, is some times made under adverse circumstances, by means of the cinex camera there are many films to study. In other words, this cinex camera practically gives us a permanent fluroscopic record. Hence it is evident that with a combination of intravenous urography and the moving pictures our diagnostic facilities are vastly improved and the patient saved much discomfort. It is also apparent from the combination that much information about the physiology of the kidney and ureter will be obtained. The expense of these agents so far prevents their general use, but later they will probably be made more available.

In these days of increasing traumatic surgery the kidneys come in for important notice. Rupture of the capsule of the kidney not uncommonly occurs. I have in mind a patient who developed a doughy mass in the right lower quadrant following injury to the right kidney, presumably a perinephritic hematoma. The general condition of the patient permitted a policy of watchful waiting with the result that the mass slowly absorbed without infection and later examinations showed a normally functioning kidney on the injured side. With careful observation many of these ruptured kidneys may be saved.

Calculi of the kidney and ureter still occasion confusing diagnostic impressions. I recently heard a roentgenologist of international reputation say that he believed that almost 30 per cent of small ureteral and kidney calculi were missed in plain films. It is, therefore, not uncommon for a patient to pass an undiagnosed calculus and an infection clear up following ureteral dilatation. Due to difficulty in technique the wax tipped catheter is not used with sufficient regularity in the male.

Nephrotosis in its varied positions causes symptomatology commensurate with its change in position. Some of these cases of slight mobility and rotation are extremely difficult of diagnosis. Like early renal tumors, repeated pyelograms at intervals are necessary. Dr. Lewis has shown that nephroptosis can occur without a general visceroptosis. I agree with him that more of these should be operated and I believe that the method of operating described by Deming in the Journal of the American Medical Association some months ago is the operation of choice.

Anomalies of the kidneys and ureters may be easily overlooked unless there be a careful search in the bladder and urethra for aberrant ureteral openings and unless the precaution be taken of drawing the catheter well down in the ureter before the injection preliminary to pyelogram. The anomalous conditions of the urinary tract may and do give rise to very misleading symptoms. By virtue of their tendency to urinary stasis they favor persistent infection, which at times is difficult to cure.

Tumors of the kidney should be written about as an entire chapter; however, a few words will suffice here. Early diagnosis, of course, is essential. Repeated pyelograms may be necessary to watch the changes as they occur in the kidney pelvis before positive diagnosis may be given. Familiarity with interpretation of pyelograms is of great importance here. Cysts of the kidney afford the same difficulties of early diagnosis, but fortunately they are rare.

Tuberculosis of the kidney also causes extreme perplexities of diagnosis in early pathology, especially in the absence of finding the organism. I still believe that carefully searching the urine for the organism is by far the best test. I am glad to see from the recent literature on tuberculosis of the kidney a strong tendency toward conservatism in the treatment of this condition.

The technical developments in diagnostic methods have been so rapid throughout medicine that occasionally it is wise to pause and evaluate the newer procedures.

In order to obtain diagnoses easily and quickly specialists particularly are apt to forsake their clinical knowledge for impressions gained by instrumentation.

It is quite possible to err in paying too much attention to method and not enough to clinical evidence. Von Lichtenberg said last year at the meeting of the American Urological Association that danger had arisen from precise instruments of diagnosis. At times they cause "defects of conception and defects of knowledge which give rise to therapeutic failures."

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FLUOROSCOPIC EXAMINATIONS OF UNIVERSITY STUDENTS

Kattentidt reports the findings among students of the University of Munich. In the winter of 1929-30, he made fluoroscopic examinations of 1,768 students (1,363 males and 405 females) as part of the compulsory physical examinations at matriculation. Some evidence of tuberculosis was found in 14.5 per cent. In most cases, the tuberculous lesion was inactive, a few were partially active, but in six cases, or 0.34 per cent of the entire series, there was an open lesion. These

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six cases all occurred in males. At the same time, 772 students (699 males and 73 females) were examined at their own request. The findings were substantially the same as among the "compulsory" group. In the previous summer semester (1929), the percentage of tuberculous lesions found in 1,437 male students was 22.6 per cent and 0.49 per cent open lesions, and of 360 female students 15 per cent tuberculous lesions and 0.28 per cent open lesions.

Combining the findings for the two semesters of compulsory and voluntary examinations of 4,836 students of both sexes, the results were as follows:

Inactive lesions	14.8 %
Partially active lesions	1.3 %
Active closed lesions	
Open lesions	
•	

Total tuberculous lesions found....16.66%

The author cites the findings of Kayser-Petersen and Wiewiorowski, who examined male university students. Adding this series to his own, he finds that in the combined groups of 6,513 apparently healthy young men between 20 and 30 years of age, 30 cases or 0.46 per cent had open tuberculosis. This figure, he believes, represents the incidence of tuberculosis among this group at a certain definite time.

Development of Activity During Semester

Further cases of active tuberculosis may develop in the group, as shown in repeated examinations. Thus, of 2.296 students examined in the summer semester of 1929, four more students (male) developed open tuberculosis and one an active closed tuberculosis up to June 25, 1930. Of the students examined in the winter semester of 1929-30, one additional case of active closed tuberculosis developed. Thus, in the course of a year, the incidence of open tuberculosis increased from 0.48 per cent to 0.65 per cent.

Brief clinical histories are given in the eleven cases (eight with open and three with closed lesions) discovered in the winter semester. The lesion was usually of the chronic interstitial type; the sputum was positive for tubercle bacilli in seven cases, negative in three cases and no sputum was obtainable in one case. Physical examination showed no evidence of tuberculosis in seven of these eleven cases. This would indicate that physical examination alone fails to reveal tuber-

culosis in a larger percentage of cases than has been suspected. In these eleven cases, eight had open lesions as shown by the positive bacteriological findings in seven cases and the clinical findings in one case. Yet none of these showed large areas of destruction; the author has often been surprised to find tubercle bacilli in the sputum in cases in which there was little evidence of a destructive process.

Supervision of Cases Necessary

Continuous supervision of such cases is necessary, however, as shown by the case of one student, who showed hilus changes on her first examination, and no definite changes on re-examination half a year later (no lesions in the pulmonary tissue). Yet ten days after this second examination, this student had a pulmonary hemorrhage, which was thought to be due to bronchiectasis, as the sputum was negative and the red cell sedimentation velocity was normal. As a matter of precaution, she was sent to a sanatorium for observation and there pulmonary focal lesions developed suddenly with positive sputum; the tubercle bacilli persisted in the sputum for several months. This was the only case in which signs of activity developed in cases with inactive lesions within six months. But this is not remarkable, since tuberculosis is a decidedly chronic disease; it indicates that these cases must be kept under prolonged supervision.

Among 44 cases diagnosed as partially active in the summer semester (1929) two students developed symptoms that necessitated sanatorium treatment. In one of these cases, there was an increase in the pulmonary lesion, and the sputum showed a few tubercle bacilli. In the second case, the pulmonary lesions showed little change, but new adhesions had developed, and the patient's general condition was poor.

Types of Lesions

A study of the types of tuberculous lesions found at the different ages in the 2,540 students examined in the winter semester showed 457 students under twenty years of age (17 to 19), the great majority over twenty years of age (from 20 to 30 years). The early forms of tuberculous lesions, including exudative pleurisy, occurred only at the earlier ages, mostly at twenty years or younger. Most of the cases of open tuberculosis occurred at twenty-one years of age or later, only

two cases at the age of twenty, and none before the age of twenty. The highest percentage of cases of open tuberculosis occurred at the age of twenty-one (in 0.78 per cent of students at this age). The focus of infection was demonstrable only in six of the nineteen active cases of tuberculosis.

Health Care of Students

The records of the results of the physical examination and of the fluoroscopic examination are filed with the university. The student is also given a printed card showing the result of the fluoroscopic examination, and whether there is any indication of tuberculous lesion in the lung, whether such lesions are entirely inactive or show any signs of activity, and whether any type of athletics is permissible. This brings the patient into contact with the athletic medical director, where this is advisable, and indicates whether further supervision or examination is desirable, or whether immediate treatment is necessary. The author is of the opinion that certain types of sports and gymnastic exercise are of definite value in the treatment of inactive tuberculosis; and that the close cooperation established with the athletic medical director by the system adopted is of definite value for the students, and for the further study of the effect of athletics on respiration and circulation in relation to the effects on tuberculosis.—Fluoroscopic Examination in the Second Semester at the University of Munich, B. Kattentidt, Ztschi. f. Tuber., 58:209, 1930 (October).

THE JOY OF BEING THE EDITOR

Getting out this Journal is no picnic. If we print jokes, people say we are silly. If we don't, they say we are too serious. If we clip things from other Journals, We are too lazy to write them ourselves. If we don't we are stuck on our own stuff. If we stick close to the job all day, We ought to be out hunting up news. If we do get out and try to hustle, We ought to be on the job in the office. If we don't print contributions, We don't appreciate true genius. And if we do print them, The Journal is filled with junk. If we make a change in the other fellow's write-up. We are too critical. If we don't, we are asleep. Now, like as not, some guy will say We swiped this from some other Journal. WE DID.*

*So did we. Our swipe was from The True Light, a a spiritualistic journal.

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

This month we are privileged to publish letters from two of our well-known members.

Views of our members and comments on letters published are solicited.

From the President, Dr. G. II. Edwards, Orlando, August 31, 1931:

I have read with much interest the communications published in the Journal the past two months. I am firmly convinced that creating the office of president-elect will be a good thing for the Association and especially good for the individual whom we would honor later with the office of president. The president-elect, knowing that he soon will have to shoulder the responsibilities of the office of the president, will be anxious to gain all possible information regarding routine procedure; will have in mind and become versed in the basic policies of the Association which today are followed out in a somewhat hit-and-miss manner by the untutored though willing incoming president; will become acquainted more intimately with the outstanding men in various parts of the State, because later he will be called upon to make committee appointments and being conversant with their abilities will enable him to make better selections: which three factors will make of him a better president.

There are a number of phrases and several sections of the Constitution and By-laws which need to be clarified and/or rearranged. I have called the attention of the Executive Committee to these and it was preparing a recommendation regarding changes to present to the Convention in May at Sarasota, but since the question of having a president-elect has arisen and since the sentiment seems to be so universally in favor of one, I am now taking up the matter of a more careful revision of the Constitution and By-laws with the Executive Committee and if it agrees with me in this matter, I will at once appoint a special committee that it may have time to carefully consider the matter and frame the necessary revision to present to us in May.

(Signed) G. H. Edwards, M.D.

From Dr. L. M. Anderson, Lake City, September 1, 1931:

After reading the Editorials and correspondence, "Shall we have a president-elect?" I feel there is quite a bit to be said on both sides.

If having a president-elect would improve our Association, I am in favor of it, and I see no

reason why it would not. It would give the president one year to get acquainted with the work of the Association. If the Association sees fit to change the Constitution, it should be stated that the president-elect should be a member ex-officio of all committees, and should attend all the meetings possible of the committees.

Now, with regard to the annual scientific program: Great good would come to the Association by a well balanced program. It should contain papers in which all classes of practitioners are interested.

I see no reason why there should be any very great change in the Constitution. It should merely be brought up to the present time. It is very true that many changes have occurred in the practice of medicine in the past; every doctor was formerly unto himself, but today he is just a cog or unit in a highly organized profession with its many branches and ramifications.

Let us consider well the changes we will make in the Constitution. Our Association has advanced along the road with the profession. We are not hoary with age yet.

(Signed) L. M. Anderson, M.D.

MEETING OF PUBLIC RELATIONS COMMITTEE

A meeting of the Public Relations Committee was held on August 30th, 1 p. m., at the Hotel Marion, Ocala, Chairman H. C. Dozier presiding. The following members answered roll call: Drs. H. C. Dozier, Ernest B. Milam, Homer L. Pearson, and J. Ralston Wells. The following members of the Executive Committee were present: President G. H. Edwards, Chairman Gerry R. Holden, Dr. W. H. Spiers, and Business Manager Stewart Thompson.

Pursuant to the regular order of business, the question of arrangement for State radio broadcasting was discussed. Dr. Dozier reported that Major Garland Powell, Director of Station WRUF, University of Florida at Gainesville, had indicated cordial cooperation and the following excerpts of a letter relative to this proposition was read:

"I would suggest the following outline for the proposed Medical Association Broadcasts. I am going on the supposition that the programs will be of one-half hour duration.

- 1. Opening Announcement—one minute.
- 2. Music—three minutes.
- 3. Introduction of Speaker—fifteen seconds.
- 4. Talk—ten minutes.

- 5. Announcement—thirty seconds.
- 6. Music—three minutes.
- 7. Introduction of Speaker—fifteen seconds.
- 8. Talk—eight minutes.
- 9. Announcement—thirty seconds.
- 10. Music—two minutes, thirty seconds.
- 11. Announcement—one minute.

"I think the music should consist of a string organization, and string or voice solos. Do not forget to add the human interest touch to your talks. Also explain all technical terms.

"Under separate cover I am sending you 'Radio Dont's', as well as some radio cotton (noiseless paper) to be used for the talks.

"As to the dates, I would suggest October 14th, November 11th, December 30th, January 6th, February 10th, March 16th, April 20th, May 21st. My reason for putting the two so close together in December and January is due to the fact that this is the holiday season, and people are home listening to the radio. If there is any other information you desire please let me know."

The dates as suggested by Major Powell have been adopted. Speakers are therefore scheduled for the following dates:

October 14th—"Some Interesting Medical History in Florida."—Edward Jelks.

November 11th—"The Florida Medical Association; What It Is and the Value of Its Influence to the State."—T. Z. Cason.

December 30th—"The Medical Profession"—G. H. Edwards.

January 6th—"The Medical Profession—Its Contributions to Charity in the State of Florida"—Ralph N. Greene.

February 10th—"The Medical Profession—Its Economic Contributions to the State of Florida."—H. C. Dozier.

March 16th—"The Medical Profession—Its Value to Society."—M. A. Lischkoff.

April 20th—"What Surgery Has Contributed to Society."—Roy J. Holmes.

May 21st—"What Internal Medicine Has Contributed to Society."—Robt. M. Harris.

The secretary was instructed to notify the above Doctors as to their expected time of appearance.

The radio broadcasting from individual sections of Florida was as follows: Dr. John S. Mc-Ewan reported, through Dr. Edwards, "satisfactory arrangements could be made with station in Orlando"; Dr. Homer L. Pearson reported that fifteen minutes a week could be arranged for broadcasting in Miami; Dr. Ernest B. Milam re-

ported that satisfactory arrangements could be made in Jacksonville; Dr. H. Mason Smith reported, by letter, that there had been no arrangements made in connection with the station in Tampa. The Committee has on file approximately forty radio talks on various subjects, from a squib 30 seconds in length to a 20-minute talk. These topics will be mimeographed and sent to all county medical secretaries, and from this list the weekly subject can be chosen; the entire chosen article will be sent to the society requesting it, and an individual speaker may then use the article as written, or rewrite it according to his own ideas, or merely use it as a structural background for an entirely new talk.

The Motion Picture Section was next discussed. The Committee has on file a number of motion picture releases. The feasibility of sending this list to all the county medical secretaries, having their Society discuss the time and which film or films would be acceptable, was discussed. This plan would necessarily consume several months, and very probably would not be satisfactory, therefore it was moved and seconded that "this Committee arrange a program and notify each county secretary a considerable length of time in advance the picture or pictures he should expect, asking their societies' cooperation in arranging a program around the film."

The next topic brought up for discussion was the Press Bureau. Newspapers, wherever possible, and especially in the larger centers, will be given material to print. These articles will number fifty-two, and one should appear each week. All articles put in the press will be released over the printed signature "Florida Medical Association," but to indicate the authority for the same, these articles will be signed by the President of the Florida Medical Association. This signature will remain on the article for the files of the newspapers, but not on the printed article.

The Speakers' Bureau, which also takes in a sub-heading of the Scientific Bureau, was discussed. It was thought that this was too large an undertaking to start synchronously with the other Bureaus, and should be withheld temporarily until the other Bureaus were well under way; therefore it was moved and seconded that "this Committee adopt the three major objectives for this year, 1931-1932, namely, first, Radio, incuding State and local broadcasting; second, Motion Pictures, and, third, Press." This motion was carried.

It was brought to the attention of the Committee that there have been in the past, are now,

and will be in the future various individuals and agencies with objects of pecuniary gain, who advocate employing them for various publicity schemes. Since the State has undertaken this work through the Committee of Public Relations contact as outlined, it was moved that "any scheme for the purpose of public education which is submitted by any person or persons for sale, direct or indirect, to a County Medical Society should be submitted to this Committee before any agreement is made, since this Committee has in its possession all material necessary, which will be given to any County Medical Society free of charge. All County Secretaries are to be notified of this resolution." Motion carried.

Both Dr. Edwards and Dr. Dozier remarked on the committee members' absences, and it is their request that all members make an earnest effort to be present at the next and all other meetings. At each meeting the various phases of the work are discussed and it is important that adequate personal cooperation of all members is obtained; it is necessary and vital to the success of this movement. If any member feels that it is impossible for him to attend all the meetings, barring acute illness or accidents, his request to be relieved of the appointment will be approved by the Committee and sanctioned by President Edwards.

It was considered highly important that the members of this Committee and all speakers that intend to speak over the radio attend a meeting for the purpose of learning the approved methods of talking over a radio, and accustom themselves more or less to them. With this end in view, the next meeting will be held in Gainesville Thursday, October 8th, which will be well in advance of the first radio talk to be delivered by Dr. Jelks from that station on October 14th. The hour and the place for this meeting will be announced later. All committee members, Executive Committee of the State and all State Broadcasting appointees will be notified to be present at this meeting.

Meeting adjourned at 3:15 p. m.

(Signed) J. RALSTON WELLS, M.D.,

Secretary, Public Relations Committee.

Dr. Stewart Thompson, through the Florida Medical Association, is to make mimeographed copies of all radio talks and press articles. All press releases, as agreed in the meeting of July 5th, will come through the Executive Committee, and this Committee, from the offices of the Florida Medical Association, Box 81, Jacksonville.

STATE NEWS ITEMS

A pre-convention meeting was held by the Sarasota County Medical Society, August 10, 1931. The meeting was held at Dr. Joseph Halton's cottage on Sarasota Beach. The object of the meeting was to put in motion plans for entertaining and conducting the Florida Medical meeting to be held in Sarasota in 1932. A survey of the city was made to determine the place best suited to meet the various requirements. A general discussion of plans took place and the Sarasota County Society especially wishes to thank the following men for their suggestions and help:

Dr. G. H. Edwards,

Dr. Shaler Richardson,

Dr. Gerry Holden,

Dr. M. J. Flipse,

Dr. Wm. H. Spiers,

Dr. Stewart Thompson.

All of these men were present and we feel that with such help the 1932 meeting is bound to be a big success.

Dr. N. A. Baltzell of Marianna was recently appointed to succeed himself as a member of the State Board of Medical Examiners.

Dr. J. H. Pound, a member of the staff of the Florida Hospital for the Insane at Chattahoochee, was appointed superintendent to succeed the late Dr. James Q. Folmar.

Dr. J. E. Abras of Miami was convicted by a jury in the United States District Court on July 14th of selling narcotics. Dr. Abras is not a member of organized medicine.

Dr. and Mrs. Frank C. Metzger of Sarasota announce the birth of a daughter, Martha Metzger, on July 3, 1931, at the Sarasota Hospital.

Dr. J. S. McEwan, Orlando, has returned to Baltimore for further treatment of an eye which kept him on the inactive list for three months last winter.

Dr. C. E. Tumlin of Miami recently made a trip to Tallahassee in the interests of the State Board of Medical Examiners.

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Dr. E. C. Swift, Jacksonville, secretary of the Florida East Coast Medical Association, announces that the proposed meeting in Jacksonville on October 2 and 3 has been postponed indefinitely. A personal letter has been mailed to each member, containing full information of action taken by the officers.

* * *

Dr. G. H. Edwards, Orlando, president of the Association, made a brief visit to Jacksonville this month, calling on the secretary and business manager. President Edwards' enthusiasm and interest in organized medicine is keenly felt wherever he goes.

Dr. Bundy Allen of Tampa returned August 16th on the liner Dresden from Paris, having attended the International Congress of Radiology.

* * *

Dr. George C. Johnston, who has spent several months at Bemus Point, New York, has returned to 217 E. Amelia Avenue, Orlando.

The marriage of Dr. Kenneth Phillips of Miami to Miss Shirley LeMon took place July 3d at Miami.

The American College of Physicians will hold its Sixteenth Annual Clinical Session at San Francisco with headquarters at the Palace Hotel, April 4-8, 1932. Following the Clinical Session, a large percentage of the attendants will proceed to Los Angeles where a program principally of entertainment will be furnished April 9, 10 and 11.

Announcement of the dates is made particularly with a view not only of apprising physicians generally of the meeting, but also to prevent conflicting dates with other societies that are now arranging their 1932 meetings.

Dr. S. Marx White, of Minneapolis, is President of the American College of Physicians, and will arrange the Program of General Sessions. Dr. William J. Kerr, Professor of Medicine at the University of California Medical School, San Francisco, is General Chairman of local arrangements, and will be in charge of the Program of Clinics. Dr. Francis M. Pottenger, of Monrovia, is President-elect of the College, and will be in charge of the arrangements at Los Angeles. Mr. E. R. Loveland, Executive Secretary, 133-135 S. 36th Street, Philadelphia, Pa., is in charge of general and business arrangements, and may be addressed concerning any feature of the forthcoming Session.

Dr. L. H. Dame was host to the Pasco-Hernando-Citrus County Medical Society Thursday evening, August 13th, in Inverness. A delectable steak and fried chicken dinner with other tasty dishes, was served at the Orange Hotel at seven o'clock. After dinner, the doctors were invited over to Dr. Dame's office where discussions and case reports were given. Dr. A. C. Hamblin, district health officer, of Brooksville, gave a splendid address on public health work. The meeting adjourned upon Dr. Moon's invitation to the society to meet with him in September.

* * *

Dr. J. Maxey Dell of Gainesville recently announced his intention to run for Congress. If Dr. Dell is elected, he will succeed Representative R. A. Green.

* * *

Dr. N. A. Upchurch, city health officer of Jacksonville, recently called a meeting of the City Board of Examiners of Midwives to formulate regulations conforming to the 1931 legislative act governing activities of these practitioners. Dr. A. D. Stollenwerck and Dr. S. R. Norris are the other two members of the board.

* * *

Dr. S. A. Folsom, Orlando, has returned after spending two months in Pennsylvania vacationing.

JAMES QUITMAN FOLMAR

The sudden death of Doctor James Quitman Folmar, Chattahoochee, removes one of the outstanding figures of the Florida Medical Association, a public servant that the state could ill afford to lose.

Dr. Folmar was born May 11, 1891, at Goshen. Alabama. His preliminary training was received at Piedmont College, Demorest, Ga. He received the degree Doctor of Medicine from Emory University School of Medicine in 1914. He served as interne at Piedmont Sanatorium, Atlanta, then as assistant to the late Dr. Floyd McRae for four years, after which he entered the World War as first lieutenant and was stationed at Augusta, Ga. Following the war, he located for general practice at Bonifay. Within a short period, he was made clinical director and chief surgeon to the Florida State Hospital, and in addition to this position, he was appointed by Governor Martin

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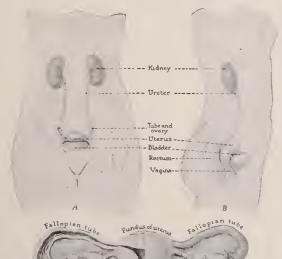
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as superintendent of this institution. He held both positions at the time of his death.

Dr. Folmar married Miss Leila J. Turner, June 1, 1918, at Anniston, Ala. Mrs. Folmar and one daughter Martha Elizabeth, age 12, survive. Dr. Folmar succumbed to coronary sclerosis on August 8th, and was buried August 10th at Oxford, Ala., where his wife and daughter go to make their home with Mrs. Folmar's parents.

Dr. Folmar was ambitious, conscientious, quiet and unassuming; he inspired confidence, loyalty and devoted friendship from those with whom he came in contact. His greatest attribute was that he was truly a friend to humanity. By virtue of these characteristics he was naturally sought as a leader in and outside of his profession. He was past president of the Chattahoochee Luncheon Club, past worshipful master of the Masonic lodge, past president of the second district medical society, and, at the time of his death, second vice-president of the Florida Medical Association.

"Whereas, we, the members of the Second District Medical Society, feel deeply the loss of our brother and past president of this Society, Dr. James Quitman Folmar;

"Therefore, be it resolved, that the members of the Second District Medical Society express their sorrow in the passing of Doctor Folmar; that a copy of this resolution be entered on the minutes of this Society; that a copy be sent to members of his family and that the same be published in the Journal of the Florida Medical Association and in the local press.

JULIUS C. DAVIS, M.D., B. F. BARNES, M.D.,

Committee."

Dr. Anna A. Darrow, Ft. Lauderdale, recently returned from a six weeks' vacation trip to Chicago via New Orleans.

Dr. A. H. Freeman of Ocala attended the Convention of Rotary International at Vienna, Austria, in June. He also did post-graduate work in ophthalmology in the Fuchs, Lindner and Meller Clinics at the University of Vienna, returning late in August.

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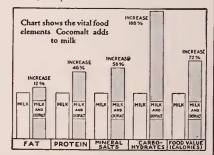
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The following message is from our new National President, Mrs. Arthur B. McGlothlan, of Saint Joseph, Missouri:

"The reports of the chairmen of the various national committees and of the state presidents indicate unmistakably to the Auxiliary women everywhere that as doctors' wives we have a definite sphere of influence as members of lay women's organizations. As such we may form a strong bond between the medical profession and the lay public.

"Because of this possibility we shall make every effort this year to strengthen our organization both in numbers and in quality of work done.

The greatest demand made upon us is for the right kind of source material for health programs, and for health program speakers.

"We are attempting to supply this information through a selected packet of literature, assembled by the Bureau of Public Information of the American Medical Association; by leaflets on communicable diseases compiled from the best recent medical literature and approved by a member of our advisory committee appointed for that purpose; by the dissemination of leaflets on 'Some Contributions of Modern Medicine to the World'; by announcement of the American Medical Association radio broadcasts; and by using our best energies to promote the circulation of Hygeia.

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"We believe that one of the best services we can render to the medical profession is to make our state and national conventions so attractive that great numbers of our women will be entired to attend and will influence their husbands to come.

"The recent meeting in Philadelphia showed that a convention can serve such a purpose. To this end we are already planning to make the convention in New Orleans the best yet if possible and we herewith invite all the doctors' wives to come and bring their husbands.

"I hope your Press and Publicity Chairman will let me talk with you again. Always read her reports and those in the Bulletin of the American Medical Association. In the Bulletin are two pages edited this year, as last, by Mrs. Walter Jackson Freeman, our national president-elect. I commend those pages and these to you and ask your support to make our departments co-operative, useful and successful.'

We have already published the names of the new officers elected at the National Convention in Philadelphia, but perhaps it might be of interest to the State Chairman of Standing Committees. to know the names of the new National Chairmen of their respective national committees. They are as follows: Program—Mrs. George H. Hoxie. 3719 Pennsylvania Ave., Kansas City, Missouri: Finance—Mrs. Thos. O. Freeman, 1204 Wabash Ave., Mattoon, Ill.; Legislation—Mrs. Arthur A. Herold, 1166 Louisiana Ave., Shreveport, La.; Public Relations—Mrs. A. Haines Lippincott, 406 Cooper St., Camden, N. J.; Hygeia—Mrs. Rogers N. Herbert, 1509 Stratton Ave., Nashville, Tenn.; Revisions-Mrs. Chas. W. Garrison, 317 Ridgeway St., Little Rock, Arkansas; Press and Publicity-Mrs. Milton P. Overholser, Har-

Here

of the one advertisements of The Sugar Institute

The advertisement reproduced here is one of the series appearing in publications throughout the country. In order to keep the statements in accord with modern medical practice, they have been submitted to and approved by some of the leading authorities in the field of human nutrition in the United States. The Sugar Institute, 129 Front Street, New York.



When sugar is added with salt to stews, meat loaves and pot-roasts, the improved flavor will delight you:

CHEAR cuts of meat can be made deliciously tender if cooked long and slowly. But, do you know that the flavor of such meat and its gravy can be surprisingly improved. if a dash of sugar is added during this cooking process?

Successful cooks have proved the value of sugar in seasoning meat. They will tell you that salt by itself overcomes flatness, and the addition of sugar heightens

the ment flavor to the fullest

A dash of sugar to a pinch of salt, or equal parts of each, are good rules to follow in meat cookery. Try this idea in stews, meat loaves, pot-roasts or braised meat dishes - also in vegetables. Most foods are more delicions and nourishing with sugar. The Sugar Institute, 129 Front Street. New, York,

C'Good food promotes good health" .

JUNIOR



A FRAME for R E G 'L A R YOUNGSTERS



Patented

FOR THE CHILD who "is so hard to keep in glasses", the Junior frame has been designed. Children like it because it's comfortable and good-looking. Parents like it because it will stand more than the usual amount of rough treatment. You'll like it because it answers the question—"How can I keep my child in glasses?".

Examine a Junior frame. Note the braced construction, the rocking pads which fit so comfortably, the handsome engraving — just like on Mother's and Dad's glasses.

When you prescribe glasses for a "reg'lar" youngster, it would be a favor to suggest a Junior frame.

With preparation for school the topic of the day, the right glasses for children is a timely subject.



J245

AMERICAN OPTICAL COMPANY

risonville, Missouri; Printing—Mrs. Samuel C. Red, 817 Caroline Ave., Houston, Texas; Archives—Mrs. Southgate Leigh, 526 Shirley Ave., Norfolk, Va.; Historian—Mrs. Allen H. Bunce, 368 Ponce de Leon Ave. N. E., Atlanta, Ga.; Parliamentarian—Mrs. William S. Tomlin, 1820 North Illinois Ave., Indianapolis, Ind.

* * *

Your Editor is sending out an S. O. S. call to State Chairmen of Standing Committees, to all Presidents of County Auxiliaries and to members of the Florida Auxiliary to please send in material for this page; personal news items, and any news of the activities of your organizations! Let's have some local news for next month's Journal!

ADVERTISERS' NOTES

The Surgical Supply Company has opened a new store in the city of Miami, located at 23 N. E. Second Avenue. This announcement has just been released by Henry L. Parramore, president and general manager, Jacksonville. This Company has carried a continuous advertisement in the Journal for many years.

WHEN, AS AND IF

the bottle-fed baby exhibits symptoms indicating partial vitamin B deficiency—described by Hoobler as (1) anorexia, (2) loss of weight, (3) spasticity of arms and legs, (4) restlessness, fretfulness, (5) pallor, low hemoglobin, etc.— Dextri-Maltose with Vitamin B may be used in adequate amounts (up to 71 Chick-Roscoe units) without causing digestive disturbance. ethically advertised product derives its vitamin B complex from an extract of wheat germ rich in B and brewers' yeast rich in G. Physicians who have attempted to make vitamin B additions to the infant's formula but who have been obliged to abandon same due to diarrheas or other unfortunate nutritional upsets, will welcome Mead's Dextri-Maltose with Vitamin B. This is a tested product with rich laboratory and clinical background and is made by Mead Johnson & Company, a house specializing in infant diet materials.

Not all infants require vitamin B supplements, but when the infant needs additional vitamin B, this product supplies it together with carbohydrate. In other cases, the carbohydrate of choice is Dextri-Maltose No. 1, 2 or 3.

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THE WALLACE SANITARIUM

MEMPHIS, TENN.

WALTER R. WALLACE, M.D. HUGH W. PRIDDY, M.D.



FOR THE TREATMENT OF

DRUG ADDICTIONS.

ALCOHOLISM, MENTAL AND

NERVOUS DISEASES

LOCATED IN THE EASTERN SUBURBS OF THE CITY. SIXTEEN ACRES OF BEAUTIFUL GROUNDS. ALL EQUIPMENT FOR CARE OF PATIENTS ADMITTED.



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when you prescribe



Self-rising — contains no starch, no gluten
Ask for nearest Depot or order direct

LISTER BROS. Inc. 41 East 42nd Street NEW YORK, N. Y.

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ALL PRODUCTS ADVERTISED IN THIS JOURNAL HAVE BEEN APPROVED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION. THEY ARE RELIABLE.

THE TUCKER SANATORIUM, Incorporated 212 West Franklin Street (Corner of Madison) RICHMOND, VIRGINIA



Private Sanatorium for neurological cases under the charge of Drs. Beverley R. Tucker, Howard R. Masters and James Asa Shield. Departments of massage, hydrotherapy and occupational therapy.

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Telephone 4381

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A. W. RUUS, President

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COMBS FUNERAL HOMES Ambulance Service

Phone 32101 MIAMI, FLORIDA Phone 52101 MIAMI BEACH, FLA.

FERGUSON UNDERTAKING CO.

1201 South Olive
WEST PALM BEACH, FLA.

A new protein milk in sterilized liquid form that is especially recommended for cases of summer diarrhea, is now available to physicians. It is probably one of the most convenient milk products ever offered to physicians as it is in concentrated liquid form and hermetically sealed in small six-ounce cans. It never gets rancid and keeps in any climate. Since it is sterile, boiling is unnecessary.

This useful new product is identified by the trade name SMACO product number 201 Liquid Protein Milk and is prepared by the Research Division of S. M. A. Corporation. Many physicians refer to this product as Casein Milk, Eiweiss Milch or Finkelstein formula.

A review of the recent literature on the action of Liver Extract No. 343 in the treatment of pernicious anemia, suggests a number of generalizations:

- 1. That the optimum maintenance dosage is an individual consideration which can be determined accurately only by repeated blood examinations by the physician, and that a patient whose blood count has been brought to normal may continue for a year or more on a dosage of potent substance that is less than the required maintenance dose, but that eventually the need of a higher maintenance dose will become evident.
- 2. That during infection and fever it must be expected that the hematopoietic response will be inhibited but that an adequate dosage of liver extract should nevertheless be continued.
- 3. That if single massive doses of liver extract are given the excess is not necessarily wasted, but may continue for a limited time at least to give results similar to those to be expected from a dosage of three vials daily.
- 4. That "the average gain in red blood-cells at the end of one month's treatment bears an inverse relation to the level of the red blood-cells before treatment was begun," and that in uncomplicated cases the number of red blood-cells produced at the end of one month by a daily dosage of three vials of Liver Extract No. 343, is essentially the same as that produced by higher dosages of four to ten vials per day.

Liver Extract No. 343 is supplied through the drug trade in boxes containing two dozen vials of powdered extract. The contents of each vial represents material derived from 100 grams, or about 3½ ounces, of fresh raw liver.



See Description, Journal A. M. A. Volume XLVII, Page 1488 scientific combination of Bismuth Subcarbonate

A scientific combination of Bismuth Subcarbonate and Hydrate suspended in water.

Each fluidrachm contains 2½ grains of the combined salts in an extremely fine state of subdivision.

Medicinal Properties: Gastric Sedative, Antiseptic, Mild Astringent and Antacid.

Indications: In Gastro-Intestinal Diseases, Diarrhoea, Dysentery, Cholera-Infantum, etc. Also suitable for external use in cases of ulcers, etc.

E. J. HART & CO., Ltd., Manufacturing Chemists NEW ORLEANS

A characteristic of Mead's Powdered Lactic Acid Milk No. 1 (containing Dextri-Maltose) is the finely divided soft curd which never clogs the nipple. In a few moments, any mother can carry out the simple procedure required without error — a saving in time to her and an assurance to the physician that the feedings are correctly prepared. This product never curdles; it is always ready, and quickly reliquefied. No ice is necessary to keep the powder. It is convenient while traveling. Samples and literature on request. Mead Johnson & Company, Evansville, Indiana, U.S.A.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

	EDULE OF MEETINGS—	COMPONENT SOC			SSOCIATION	
COUNTY SOCIETY	SECRETARY	Date	ME:	ETINGS	Y 1	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday		Place White House	Luncheon? Yes.	77%
Bay	D. M. Adams, M.D., Panama City.					100%
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		80%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Com-	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		86%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally.	81%
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	100%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	8+%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	84%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	82%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	83%
Madison	Geo. O. Davis, M.D., Madison.					68%
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.		Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	64%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Court House	Yes.	90%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg.	Every other Friday	8:00 P.M.	500 Power & Light Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.		Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varie s	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
Washington- Holmes						25%
	NOTE-Secretaries P	lance submit inform	ation to some	lete the above sehe	Jula	

NOTE-Secretaries: Please submit information to complete the above schedule.



IPRAL SQUIBB

Approximates the ideal hypnotic

In alleviating restlessness and irritability following operations, and in mental and nervous cases, Ipral Squibb has been found by clinical experience to be particularly useful.

Ipral Squibb is effective in small doses and induces sleep which closely resembles the normal. It is rapid in action, of low toxicity, and when administered in therapeutic doses no untoward effect on the heart, lungs, kidneys or gastro-intestinal tract has been observed. It is marketed in 2-gr. tablets in bottles of 10, 100 and 1000.

For literature, write to Professional Service Department, 745 Fifth Avenue, New York

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NEW YORK

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For urethral administration

Solargentum is an effective, mild silver protein. In prophylaxis and treatment of gonorrhea, Solargentum has been found to be satisfactory when used in 10 per cent solution. It is quickly and freely soluble in distilled water.

Solargentum acts as an antiseptic without irritation or appreciable astringent effect.

It is marketed in packages of 1 oz., ½ lb., and 1 lb., and also in bottles of 100 and 500 tablets, 4.6 gr. each.



THE JOURNAL

OF THE —

Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE F	LORIDA MEDICAL ASSOCIATION, INC.			
volume xviii Jacksonville, Flor	Jacksonville, Florida, October, 1931 Yearly Subscription, \$2.00 Single Copy, 20c			
C O N T	CENTS OF MEDICINE OCI 23/33/ PAGE			
Conservative Renal Surgery	Granuloma Inguinale			
Roy J. Holmes, M.D., F.A.C.S., and Milton M. Coplan, M.D., Miami.	F. E. Daves, M.D., Chattahoochee.			
The Enlarged State Board of Health Program 168 Henry Hanson, M.D., Jacksonville.	Editorials: (1) The Annual Meeting; (2) Proposed Revision Constitution and By-Laws187, 188 Correspondence188			
Endocervicitis	State News Items			
Focal Infections, the Resulting Morbidity and Treatment for Same	Advertisers' Notes			
Witch Doctors and Their Practices	Schedule of Meetings—Component Societies of Flor- ida Medical AssociationInside Back Cover			

Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

NEXT ANNUAL SESSION, SARASOTA, MAY 3-4, 1932

Because of higher tolerance

MEAD'S DEXTRI-MALTOSE WITH VITAMIN B

may be added to the infant's cow's milk-and-water formulae in sufficient amounts (up to I½ oz. per day when indicated) to supply in addition to what the cow's milk supplies:

per day

| 375 Units Vitamin B Complex (Sherman)
| 140 Units Vitamin B (B₁)—(Chick-Roscoe Modification)
| 69 Units Vitamin G (B₂)—(Chick-Roscoe Modification)
| 5.66 mgs. natural Iron Salts
| 168 Calories

—without danger of intestinal irritation or other digestive upset.

"Dextri-Maltose with Vitamin B" is used as a carbohydrate for bottle-fed infants for the appetite-and-growth-stimulating properties of the vitamin B complex it contains, particularly in cases of partial vitamin B deficiencies described by Hoobler as anorexia, loss of

weight, spasticity of arms and legs, rigidity of neck, restlessness, pallor, low hemoglobin. The vitamin B factors are provided by the addition of extracts of wheat embryo and yeast. 1 gm. is equivalent in vitamin B complex to .4 gm. dried yeast or .8 gm. wheat germ.

The Fourth Element in the Prescription

Until recently there were only three elements to be considered, spheres, cylinders and prisms.

Now we recognize the fourth element — Glare Absorption. Everyone living in this modern age is subject to glare. Artificial light, bright walls, concrete roads and sidewalks all produce glare.

Some patients' eyes so function that they do not need glare protection but the vast majority (about 72%) are more comfortable with Glare Absorption lenses than with white lenses.

Whenever the Glare Test* shows the need of protection prescribe ORTHO-GON SOFT-LITES in the proper shade. Thus you eliminate glare without ultraviolet absorption, you furnish lenses that are becoming, and you enhance your own professional prestige by giving an added measure of comfort.

ORTHOGON SOFT-LITES in single vision and bifocals are available from every Southeastern Office.

*Details of the Glare Test will be sent on request.



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RICHMOND ROANOKE WINSTON-SALEM The liberal use of cow's milk in the child's diet is desirable for its calcium and phosphorus content when its well-known deficiencies in iron and vitamin B(F) are made good with Mead's Cereal

THE Journal of the American Medical Association based on recent research by Sherman and Booher², raises the question as to whether the relatively large consumption of milk (up to a quart a day) should be routinely recommended, on account of the deficiency of milk in iron and the resultant relation to anemia. On the other hand, if the milk ration is

decreased and ordinary cereals substituted, not only is the iron deficiency far from being made good, but there remains the well-known fact that most cereals are seriously deficient in calcium and vitamin G. Fortunately, the recent development by the Pediatric Research Foundation of a new cereal, which when

0.2211 gms.

Calcium

in one oz.

MEAD'S CEREAL

MEAD'S CEREAL

IS RICH
IN CALCIUM

Figures show gms. calcium per ounce of cow's milk, farina, rolled oats and Mead's Cereal.

0.034 gms. Calcium in one oz. Cow's Milk

> 0.0135 gms. Ca per oz. Rolled Oats

> > 0.0039 gms. Ca in one oz. FARINA

0.0011 gms. Iron in one oz. Rolled Oats

CEREAL IS
RICH
IN IRON

MEAD'S

0.0068 gms.

Iron

in one oz.

MEAD'S CEREAL

0.00022 gms. Fe per oz. FARINA

10.00006 gms. Fe

Figures show gms.
iron per ounce
of cow's milk,
farina, rolled oats
and Mead's
Cereal.

used with milk not only makes good its iron and vitamin B deficiencies, but also supplies what no other cereal supplies in such outstandingly abundant measure—calcium, phosphorus, copper and vitamins A, E and G. This new cereal was devised in the Research Laboratories

of the Hospital for Sick Children and the Department of Pediatrics, University of Toronto, and is exclusively licensed for production by us. It is called Mead's Cereal, is advertised only to physicians, and is supplied in 1- and 4-lb. packages through drug stores.

MEAD JOHNSON & CO.

Pioneers in Vitamin Research Evansville, Ind., U.S.A.

¹ Editorial, Storage of Calcium, J.A.M.A. 96:197 (1931). ² Sherman, H. C. and Booher, L. E., The Calcium Content of the Body in Relation to that of the Food, Proc. Soc. Exper. Biol. & Med. 28:91 (1930).

PRINCIPAL FUNCTIONS OF CALCIUM

(1) Calcification of bones and teeth (2) Regulation of sympathetic nervous system (and through the vagus, cardiac muscle tone) (3) Maintenance of calcium-phosphorus ratio in rickets and tetany (4) Control of normal salt balance in blood and body fluids (5) Maintenance of acid-base equilibrium (6) Formation of calcium caseinate compounds in food digestion (7) Coagulation of blood (8) Antagonism to toxic effects of potassium and magnesium ions.

Refs: F. R. Fraser, J. C. Hoyle, etc., etc.

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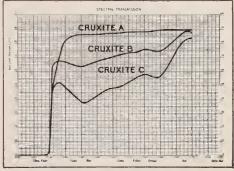


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AND so do many of your patients. Cruxite lenses protect eyes from glare. They absorb practically all of the irritating ultra-violet rays and enough of the visible rays to bring comfort—with no sacrifice of clear vision.

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J261

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RAHWAY, N.J.



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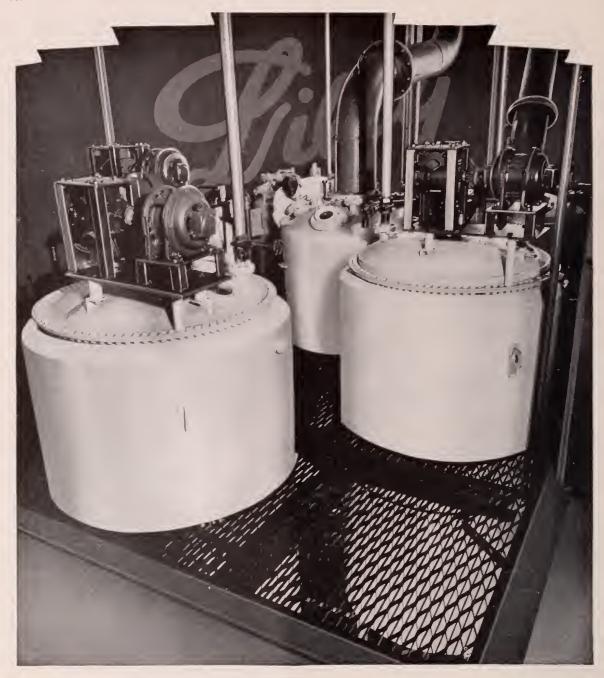
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HE production of Liver Extract No. 343, used in the treatment of pernicious anemia, involves elaborate equipment. The two storage tanks of the extract in process, in the foreground above, are seen from the second floor level, as is the still in the center.—View in the laboratories of Eli Lillv and Company, Indianapolis, manufacturers of

ILETIN (INSULIN, LILLY) -:- LIVER EXTRACT No. 343 TABLETS AMYTAL -:- PULVULES SODIUM AMYTAL PARA-THOR-MONE -:- E PHEDRINE PREPARATIONS

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XVIII

Jacksonville, Florida, October, 1931

Number 4







Fig. 1. Shows interior of bladder with Thomas forcep blades entering ureteral orifice. Pan-endoscope telescope and forceps engaged in bladder sphincter.

Fig. 2. Sketch illustrating imaginary division of kidney into surgical regions.

Fig. 3. Sketch showing manner of grasping kidney for making incision.

CONSERVATIVE RENAL SURGERY*
ROY J. HOLMES, M.D., F.A.C.S.,
and
Murroy M. Cory et M.D.

MILTON M. COPLAN, M.D., Miami.

The fact that man has been endowed with two separate masses of renal tissue, each of which is more than capable of sustaining human life, can be regarded neither as evidence of nature's wastefulness nor merely as accidental. A consideration of this point as a wise and determined result of his development will further convince us that sacrifice of renal parenchyma should be undertaken only after the most thoughtful deliberation.

Surgical conservatism is largely dependent upon that indescribable quality which we call surgical judgment. This is particularly true of renal surgery.

Nephrolithotomy is not always a more conservative operation than nephrectomy. On the contrary, extensive nephrolithotomy is an extremely dangerous operation and has been employed in a large number of unsuitable cases under the mistaken idea that the operator was conservative.

One's surgical judgment may be largely influenced by one's surgical environment. Thus, the followers of Joly. the English lithotomist, may see extreme danger in every infected kidney and

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

may be much more disposed to remove such a kidney than those who follow the French school under the leadership of Legueu and Papin.

In the brief time allotted to us, it is our intention to report and discuss some of the cases that have come under our observation which will illustrate some of the important developments in renal surgery as well as the fact that our judgment has not always been above reproach.

CASE 1.—Mrs. J. R. was first seen by one of our colleagues in November, 1929. At that time, she presented all the classical symptoms of severe pyonephrosis and was critically ill. X-ray study revealed an extremely large pyonephrosis of the left kidney and immediate operation was advised as a life-saving measure. On opening the pyonephrotic sac, almost a liter of creamy, foul-smelling pus was evacuated. The surgeon was convinced that the kidney was destroyed beyond recovery. On account of the patient's condition, together with the fact that the opposite kidney contained a number of large stones, the operator wisely and very correctly introduced a large drainage tube into the sac and completed the operation without further manipulation. This tube drained freely for several months and was allowed to remain in the sinus, on account of the fact that drainage down the ureter could not be established and severe symptoms of retention and pyonephrosis invariably developed when the tube was removed. On April 3, 1930, or six months after

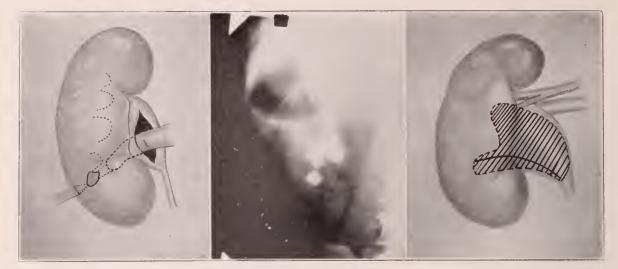


Fig. 4. Sketch illustrating approach to small stone in lower calyx at time large stone is removed through pelvic incision.

Fig. 5. Flat film of renal calculus. This type stone could hardly be removed entirely by simple pyelotomy.

Fig. 6. Sketch illustrating "pyelotomic enlargie." Heavy line represents line of incision through pelvis and its continuation into renal substance.

operation, the attending surgeon left on a lengthy vacation and requested that we take charge of the case—the tube was still in position but hardly drained enough to soil the dressing. Indigo carmine did not appear from the left orifice in onehalf hour but appeared very slightly on the dressings within six hours. Further X-ray study revealed a large calculus in the lower third of the left ureter which had been missed entirely at the first examination due to the fact that the extreme lower portion of the ureter was not included on the film. This calculus was removed by an original technique which is herein described for the first time. (Fig. 1.) The naked observation telescope of the McCarthy Panendoscope was introduced into the full bladder after maximum urethral dilatation, and the left ureteral orifice was Keeping the orifice in the field of identified. vision, an instrument known as the Thomas uterine dressing forceps was introduced into the bladder through the urethra along the side but entirely independent of the observation telescope. The tip of this instrument was brought into the field of vision and carefully introduced into the ureter until resistance offered by the stone was encountered. The telescope was then withdrawn and, aided only by the sense of touch, the forceps was carefully opened and closed until the dilatation thus procured permitted the stone to fall between the blades and be removed. This operation, of course, is limited in its usefulness and can only be done through the female urethra which permits thorough dilatation. We have been successful in removing stones in three out of four first attempts, all of which were done in our offices and without any form of auesthesia. The patients did not complain of excessive pain nor have we found it as brutal, blind or radical as many of the other methods that have been recommended. It should be attempted only by the most experienced cystoscopists.

The patient's recovery was remarkable. Today, which is one year later, she is in excellent health and repeated tests indicate that the function of the left kidney is only a few points below the normal and slightly better than that of the right kidney. The right kidney is symptomless and very little pus appears in the catheterized specimen. Should the calculi in the right kidney be removed now by extensive nephrotomy? Opinions will differ. Practically all authorities agree that multiple renal calculi should be removed as soon as possible, but, thus far, we have adopted a policy of watchful waiting.

The indications for renal surgery are, in the vast majority of cases, the results of renal calculi. The first prerequisite for the successful removal of renal calculi is that the operator must know exactly where the stone or stones are located. One must not be satisfied in knowing simply that there is a stone in the upper or lower pole of the kidney, but must definitely establish by pyelogram whether or not such stone is in the substance of the kidney, the pelvis or the upper, lower or middle calyx. The plain film and the pyelogram should be studied carefully and compared and, if

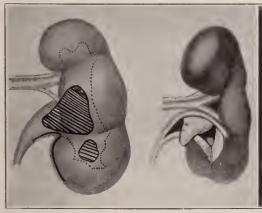
necessary, the stone should be localized as closely as possible by measurements.

The vast majority of single renal calculi and intra-renal calculi associated with stones in the kidney pelvis are in the loveer calyx. This is a very important fact to know and it is equally important, therefore, that the operator know exactly how to enter the lower calyx. Even if one chooses or is forced to remove a stone entirely confined to the renal pelvis, through the kidney substance, it is a mistake to cut down on it through the middle third or maximum thickness of the kidney. The lower calyx lies from 1 to 2 cm. from the surface. It is straight and wide and leads directly into the pelvis.

In order to open the lower calyx, it is a good idea to divide the kidney, mentally, into three equal parts, an upper, middle and lower third. (Fig. 2.) The kidney should be firmly grasped between the fingers and thumb of the surgeon's left hand. (Fig. 3.) The fingers and thumb should be well down toward the pelvis in order to prevent a small stone from being forced out of the calvx into the pelvis. A small incision is made which is bisected by an imaginary line separating the lower and middle third of the kidney. The edges of the wound are then retracted and the incision cautiously deepened to a depth of 11/2 to 2 cm, when the calvx should be reached and identified by the pearly white color of its epithelial lining. The finger can then be introduced and the stone palpated. Of course, if the stone can be palpated without difficulty through the kidney substance, it is permissible to plunge a knife vertically into the kidney until the point grates on the stone. The exposure should otherwise be made very carefully and under vision.

On several occasions, after removing a large stone from the kidney pelvis, we have removed prolongations of this stone or a separate stone from the lower calyx by making a small incision directly on to the stone in the calyx after introducing the finger through the pelvic incision for the purpose of palpating and holding the stone in place or preventing it from escaping through the isthmus. (Fig. 4.)

For practical purposes, all pelvic stones, regardless of size, can be removed by pyelotomy if the stone is strictly limited to the pelvis. Occasionally, however, to do so may produce an unnecessary amount of traumatism or the stone may be of such shape as to render simple pyelotomy unwise. (Fig. 5.) We have several methods of handling such a stone, other than simple pyelotomy or extensive nephrotomy. We have, on one occasion, followed the suggestion of Marion, with good results. In this, the so-called "pyelotomie enlargie" (Fig. 6), the incision into the pelvis is begun just above the junction of the ureter with the renal pelvis and curves upward and backward toward the junction of the middle and lower third of the renal notch. Two clamps are then placed on the edges of the renal sinus to control the retro-pelvic vessels and the incision is continued between them through the kidney substance in the line of the lower calvx. The advantages of this operation are that it gives direct access to the lower calvx and permits a complete digital exam-



Ftg. 7. Illustration of inferior nephro-pyelolithotomy after the technique of Papin.



Fig. 8. Sketch super-imposed on actual film of renal calculus which was removed by inferior nephro-pyelolithotomy.

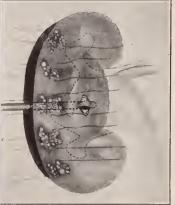


Fig. 9. Method adopted by authors for closing kidney incisions. Note fat pads under sutures, alternate placing of mattress sutures and four-wing Malecot catheter in place.

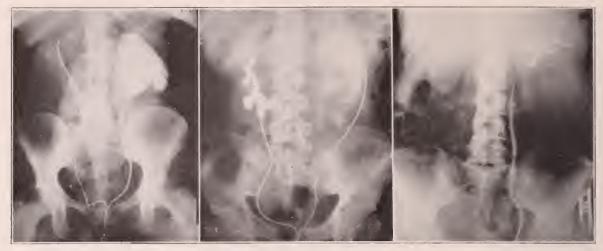


Fig. 10. Pycloureterogram of enormous hydropyonephrosis resulting from aberant blood vessel crossing ureter at its junction with the kidney pelvis.

Fig. 11. Horseshoe kidney showing left side completely filled with large stones.

Fig. 12. Solitary cyst of kidney. Nephrectomy was done although partial resection of kidney might have served with good results in this case.

ination of the whole of the pelvis and calyces with the minimum involvement of renal tissue. The disadvantage lies in the division of the retro-pelvic artery. It should never, under any circumstance, be attempted without first placing the two clamps along the edges of the wound at the renal sinus. If the vessel lies behind the posterior lip of the renal sinus and cannot be seen and ligated, the lip of the renal sinus and a small portion of the pelvis must be included in two mattress sutures, one on each side of the line of incision.

Another operation perfected by Papin and which we have used on two occasions is known as inferior nephro-pyelolithotomy. (Fig. 7.) The incision here is partly pelvic and partly renal. It is made along the lower border of the renal pelvis and carried upward until the lower angle of the renal sinus is reached. The knife is then carried through the kidney substance along its inner border opening the whole of the lower calyx and exposing the broadest and thickest portion of the calculus. (Fig. 8.) If done correctly, the retro-pelvic vessels are not injured and bleeding from this portion of the kidney is remarkably slight. In selected cases, this operation, in our opinion, is nothing less than ideal.

Extensive nephrolithotomy is indicated in cases where pyelolithotomy or any of its modifications cannot be performed, when infection is not severe and when the operator has reason to expect fairly good kidney function following the operation. It is our opinion that the method of making a comparatively small incision into the kidney and en-

deavoring to sweep the stones out blindly with the index finger should be severely condemned. The entire kidney should be thoroughly exposed and the renal pelvis and upper portion of the ureter should be plainly visible. After carefully securing complete hemostasis, the kidney should be opened in the so-called "bloodless line" from pole to pole, if necessary, in order to expose the three major calyces and the renal pelvis if these structures have been invaded by stone formation. It is our practice not to disturb the stone or any of its ramifications until the cast has been entirely exposed and freed of all tissue which might interfere with its removal. It can then be lifted out carefully with the thumb forceps and the chances of leaving small fragments are thereby greatly minimized.

Regarding the closure of the kidney incision, we have combined three worth while contributions made by the following men: (Fig 9.)

First, the method of placing particles of fat under the mattress sutures which was first suggested by Eisendrath. This is of great value, as sufficient tension on the sutures can be exerted to control hemorrhage and at the same time, the danger of the suture cutting into the kidney substance is greatly lessened.

Second, the mattress sutures are placed alternately from each side of the kidney as suggested by Young. After tying the suture over the particles of fat, the ends of the ligatures are left long. These ends are subsequently tied over the convex border of the kidney in very much the

same manner that a shoe is laced, using an end of the ligature from each side of the kidney.

Third, for drainage, we use a large four-wing Malecot retention catheter placed down into the kidney pelvis as suggested by Papin. We also use this type of catheter through a stab wound into the kidney after extensive pyelolithotomy and close the wound in the pelvis tightly if it is large. The advantages of a size 30 Malecot catheter over the ordinary drainage tube are that the catheter remains in position, its tip in the kidney pelvis, and can easily be removed. It is not necessary to place a stitch through the catheter and consequently, it is free to move with the kidney during respiration. The wings tend to guard the catheter against plugging with blood clots and, according to Papin, there is much less danger of a persistent fistulous tract if this type drainage is used.

May we say here that calculi are not the only factors that can interfere with drainage from the kidney. We have seen advanced hydro- and pyonephroses due to aberant blood vessels and ureteral stricture with periureteritis. These cases can often be relieved without nephrectomy. (Fig. 10.)

Partial resections of the upper or lower portions of the kidney or heminephrectomy is an old operation which has rapidly gained popularity within recent years. We have had no experience with this operation but have been extremely interested in the favorable reports which are now in the literature. Our experience is limited to one case in which we endeavored in an emergency to resect the stone and pus-bearing portion of a horseshoe kidney. (Fig. 11.) This was not an extremely difficult operation but the patient's subsequent cardiac death has somewhat dampened our enthusiasm. One complete half of the horseshoe was resected through a long oblique lumbar incision and we were convinced that this operation should rarely, if ever, be attempted transperitoneally.

We have seen three cases of large solitary or serous cysts of the kidney during the past five years. In two cases, the cysts were easily removed after resecting a small portion of the kidney containing part of the serous sac. The third case presented an extremely large cyst and the patient was running a low grade septic temperature due to mild pyelitis. (Fig. 12.) These facts influenced us in doing a nephrectomy, a procedure which is sanctioned by practically all the text-books. After talking with several of the authori-

ties who have written extensively on this subject, we are convinced that nephrectomy is rarely, if ever, indicated for simple solitary cyst of the kidney. Regardless of size, the cyst can always be removed and even if a portion of the wall is left attached to the kidney, the cut edges can be turned under with sutures and recurrence is extremely rare.

A few more mistakes of this type and we have been reverently convinced that there should be more rejoicing over one kidney which has been lost and is found again than over the ninety and nine that have never gone astray.

DISCUSSION

Dr. Louis Orr, Orlando:

Dr. Holmes spoke of heminephrectomy for pyonephrosis. I have a case which I would like to illustrate with a few slides.

This slide shows a duplication of the ureters with complete separation of the kidney pelves, which is conclusive evidence of two separate renal units, probably acting independently of each other. In the upper unit of kidney, you see a large number of stones with dilatation of the pelves and complete destruction of the kidney tissue. The ureter is also seen greatly dilated from the lower third up, due to a stone in that portion of the ureter. Functional tests on the lower renal unit revealed a normal dye output. The kidney on the opposite side showed an output below normal. It was considered wise to do a heminephrectomy rather than total nephrectomy, which was done.

In performing a heminephrectomy I feel that it is best to divide the kidney along the line of demarcation before the blood supply is tied off. In this way no arterial supply that might possibly be going down to the lower unit will be disturbed. I have witnessed instances where the blood supply was divided before the kidney was divided and it was found that the artery branched in the body of the kidney itself and therefore a principal source of blood for the lower unit was destroyed. It seems better to control bleeding by pressure as in a nephrotomy until after the heminephrectomy has been performed.

Dr. Roy J. Holmes, Miami (concluding):

I simply want to thank the gentlemen for their discussions.

I have nothing more to add.

THE ENLARGED STATE BOARD OF **HEALTH PROGRAM*** HENRY HANSON, M.D.,

Jacksonville.

The enlarged State Board of Health program is presented to the medical profession for criticism and we hope approval.

The existing State Board of Health was established in 1889 by an act of the Legislature and owes its origin to the rigid quarantine restrictions passed by the county boards of health during the yellow fever epidemics. The Constitution as ratified in 1886 made provision for "suppression of diseases arising within or without the State." owing to the insistance of Dr. John P. Wall, a member of the convention from Tampa. The State Board of Health was appointed in 1889 with Dr. Joseph Y. Porter as the first State Health Officer. During his 28-year term of office there was a gradual evolution in policy and before he relinquished his duties, he had established the foundation for the present organization. He was succeeded by Dr. W. H. Cox of Brooksville who held office from June, 1917, to July, 1919. Dr. Cox was succeeded by Dr. Ralph N. Greene who held office from July, 1919, to June, 1921, followed by Dr. Raymond C. Turck from June, 1921, to July. 1926, and he by Dr. B. L. Arms in July, 1926, who continued until September 15, 1929. These men all contributed valuable service to the State and materially enlarged the scope of activities.

Influenced by several years' experience in the tropics, the present incumbent has focussed his attention on malaria as a major issue for tropical or subtropical states.

An analysis of the vital statistics of Florida substantiates the malaria hypothesis. Calculations of morbidity made on the basis of 200 cases for each malaria death reveals a hitherto unheralded factor influencing economic conditions in the rural communities. On the above basis, the year 1929 represents one of the peaks in the "flowing incidence of malaria" with an estimate of 94,000 cases of the disease. A calculation based on 1,498 reported deaths for five years (1925 to 1929 inclusive) gives a morbidity of 299,600 cases of malaria for the period.

The hookworm prevalence is difficult to estimate. If one is guided by the results of laboratory findings, the incidence for rural communities varies from 25% to 80%. In a recent analysis of 100,000 routine examinations made in the

State Board of Health Laboratory approximately 25% were positive, a rate which applied to the rural communities reveals the fact that there are some 275,000 persons in this state constantly suffering from hookworm disease.

There were 255 deaths in 1929 due to pregnancy or associated with childbirth, 110 of which were in the rural communities and 145 in the urban. Maternal mortality in rural and urban districts of the U.S. Registration area, as compiled by the U. S. Children's Bureau, shows a rate per 10,000 live births of 95 for the State, 92 for urban and 96 for rural communities.

General health conditions compare favorably with those of other states even though some of our larger cities have a staggering venereal disease incidence. In the United States, it is said that there are some 600,000 cases of syphilis constantly under treatment and in addition approximately 400,000 cases of gonorrhea. Dr. Parran, Health Officer of New York State, says that only onethird of the syphilities come for treatment in the early stages of the disease. The yearly attack rate for such cases is said to be 4 per 1,000 population and 60% of cases occur in males between the ages of 15 and 45 years. Sixty per cent of the cases treated are treated by private general practitioners.

The control of the venereal disease is the most difficult task of the public health officer, and no satisfactory solution has vet been reached.

The outstanding factors (aside from venereal disease control) in the problem of the health administrator in Florida are malaria, hookworm and the high maternal mortality in rural communities.

As for malaria, the experts say that there are 200 or more cases for each death and the loss in earning capacity is 10 or more days for each case. Dublin in his book entitled "The Money Value of a Man," places this time loss for each case at about 18 days. We have made our estimate on the more conservative basis of 10 days, feeling that even that should be sufficient argument to convince our Legislators of the need of providing the means for control. The hookworm sufferer of working age is said to be only one-third efficient, still speaking simply from the standpoint of economics.

The agricultural population is the backbone of the state and nation.

No municipality is more prosperous than its surrounding rural community.

On the basis of these general principles, we

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

¹Paper on Syphilis read at Surgeon Generals' Conference, Washington, D. C., April 29, 1931.

have conducted a series of demonstrations in an effort to teach the people what the simple measures are which will protect them from malaria and hookworm infection.

With the foregoing facts in mind, the State Board of Health has considered various measures for combating the handicaps which burden the rural people of the state and about a year ago we began advocating the establishment of the rural full-time county health unit. To this end, an Enabling Act was introduced in the present Legislature and favorably reported by the Health Committee of both houses. Its fate is still uncertain. This act would enable the State Board of Health to cooperate with the counties to carry the health work of the people who most need it.

For years, the Bureau of Communicable Diseases, under Dr. Brink's direction, has carried on an active campaign teaching protective measures against communicable diseases. This Bureau has offered free prophylactic measures to all. Owing to a limited budget, the Board ruled that all therapeutic biologies should be taken from the free list and thenceforth given free of charge only to indigent patients. Among prophylactics, the 1,500 unit dose of tetanus antitoxin has been placed under the same ruling. Among medicinal remedies carbon tetrachloride is dispensed free, which is also true for limited quantities of quinine in the most malarious sections of the state.

The Bureau of Communicable Diseases has cooperated with the State Tuberculosis and Health Association in conducting diagnostic clinics. Our program includes addition of a division for study and control of this disease if the Legislature provides an adequate working fund for it.

The Bureau of Sanitary Engineering has done very effective work in improving general sanitary conditions by instituting measures for the safeguarding of water supplies and the proper disposal of human wastes. This Bureau has recently inaugurated new regulations for the sanitation of canneries which has brought commendation from the Southeastern Food and Drugs Association. Mr. Filby and his staff are available for consultation and advice on all major problems pertaining to sanitation. He is cooperating with the U.S. Public Health Service in a study of Anopheline control in the vicinity of the impounded waters of the Florida Power Corporation. Largely through Mr. Filby's efforts, the Bureau of Entomology of the Department of Labor has established at Orlando a station for the study of the Anopheline mosquitoes and other biting insects in Florida. Sanitary control of our extensive shell fish industry is an important part of the Sanitary Engineer's routine. The Bureau's most trying task is teaching and prevailing with the rural people to mosquito-proof the home and to construct and use the sanitary privy. In this lies the major elements of success or failure in our malaria and hookworm campaign.

During the summer we have a milk inspector from the U. S. Public Health Service who is conducting a state-wide survey of milk and dairy conditions.

The Bureau of Child Hygiene has made a state-wide survey of the midwife situation in which detailed histories have been taken of all midwives in a single county in each of the nursing districts. The nurses have found that a very large per cent of the midwives can neither read nor write. There is no law fixing minimum requirements for midwives nor is there any law which requires them to register and be licensed. The recommendations of the Florida Medical Association are sought in this difficult problem.

Efforts are being made by the Bureau of Child Hygiene to put into effect the recommendations of the White House Conference on maternity and infancy and the pre-school child. It is advocating a more intelligent use of the family physician and the value of periodic physical examinations. The public health nurses are devoting more time to home visits, teaching hygiene and the care of communicable diseases. The public health nurse is in a sense the sanitary officer of the bureau. The State Board of Health nurses have discontinued physical inspection of school children and are devoting all spare time to follow-up measures. The public health nurse is as indispensable to the health officer as the general duty nurse is to the practicing physician. The complete State Board of Health program for public health nursing in Florida has not been worked out in all its details.

The Public Health Laboratories are doing a constantly increasing amount of work. Looking back 21½ years we find that the total number of specimens examined in 1909 was 5.762, the total for 1930 was 177.590, a rather substantial increase but there is still need for more work both as an aid to the general practitioner and in the investigation of obscure problems. We are now facing the fact that Rocky Mountain spotted fever has become established in the Eastern section of the United States and almost conclusively proven to exist in Florida. The dog tick *D. varaibles* has been found to be a carrier of the infecting agent

and the prevalence of this tick in Florida gives additional importance to the problem. It is quite possible that many of the cases formerly reported as Brill's disease, especially the severer types, have actually been cases of the eastern variety of Rocky Mountain spotted fever. Means for a laboratory differentiation in typhus and the new invader are known but may need some refinement in technique to become of prompt value to the physician.

It may not be out of place to say that the laboratory can only serve as one of the links in the chain of evidence which forms the basis of the diagnosis in a given disease. Suggestions have been made for new blood chemical tests in the determination of malaria in those cases where the parasites do not readily appear in the peripheral circulation.

In March, an arrangement was perfected with the Rockefeller Foundation for transferring their station on field studies of malaria to Florida. This work has been established as the Malaria Research Division of the State Board of Health with Dr. Mark F. Boyd, one of the leading malariologists of the United States, as director. The general program of this Division is to study the flowing incidence of malaria over a period of ten years and to investigate this disease in all its phases. As indicated above, a spleen index has been taken which shows a spleen rate confirming some of the limited blood smear surveys made a few years ago in which we found areas having as high as 59% positive blood smears taken somewhat at random. This is regarded as one of the most important innovations and one which as time goes on will be of the greatest benefit to the state.

Finally, one more activity in addition to the daily routine. In June, we will have with us Dr. W. W. Cort, Professor of Helminthology at Johns Hopkins School of Public Health, who will conduct an ascaris survey in the portion of the state which has shown the highest incidence in the routine laboratory reports. Dr. Cort is the leading authority in this subject and has studied ascaris infestation in many foreign countries.

DISCUSSION

Dr. M. B. Herlong, Jacksonville:

This paper of Dr. Hanson's deserves our commendation and the program endorsement—especially the malarial and hookworm work. His figures show 94,000 cases in 1929, and we know that malaria in a territory where malaria is prevalent is not always seen and reported by physicians.

His report of districts showing 25% to 80% infections of hookworm should be given serious consideration not only from the physical standpoint but from the economical standpoint. I read a paper in Tampa several years ago on this subject and there was some interest taken by some counties but not the general interest that should be taken in this. Some of you know counties, settlements and localities where no improvements have been made for generations. The counties are a liability to the state and its people are classed as "ne'er-do-wells." Dr. Hanson's figures explain it all.

"No county, state or nation can be better than its people"—and in any community where malaria and hookworm infections are practically 100%, the brains of such a people are so anemic that they cannot be receptive to any civic stimuli.

I have a copy of the State Superintendent's annual report for the year ending June 30, 1930, and, gentlemen, it is well worth getting and studying.

We are spending for schools in Florida the tremendous sum of \$35,307,346 per year. For that year, the percentage of attendance was 76%, or the loss was 24% of \$35,307,346, or \$8,473,763. How much of this loss was from sickness we do not know. With this amount of our tax money involved we should know. I have figures from the individual county superintendents showing that we have more than 9% of children who have to repeat every year or go over the same school work the second time.

We know that the courses of study laid out for each grade was laid out by men and women who know what a normal child of a given age can do and where a child cannot do the work we infer that the child is not normal and have to repeat its year's work and the \$101.07 spent for that year's cost is lost. This loss in school children, not counting the loss of those of non-school age, amounts to 9% of our total school budget, or \$3,177,641.

Dr. Hanson has some very fine figures on one particular locality in one of our most progressive counties which verifies this estimate.

I am conservative but I know that our expenditures in public health work are a paying investment, or, 6% of this \$3,177.641 loss will put a health worker in every county in the State. This will help these children who are sick or who have correctable defects, such as defective eyes, ears, teeth, tonsils, adenoids, malaria and hookworm, to be able to compete with the normal child in its

school work and in its fight for existence in future life. I wish to give you a concrete example which came to my attention in one of our Duval county schools:

M. S., age 12, was promoted to the fifth grade, but her teacher reported she could not do the fifth grade work. She was put back in the fourth grade. The fourth grade teacher who had promoted her found she could not do the fourth grade work and she was put back in the third grade. Our city school inspector found this child was defective in her eyes. The father had a big family and could not purchase glasses for this child. The P. T. A. and teachers of this school raised \$10.00 for glasses and had her eyes corrected. This child then could do the work in the fifth grade, or with glasses she was able to advance three years in her work, or a saving of three years' cost to the taxpaver, or three times the per pupil cost for Duval County, which is \$87.98, or \$263.94.

Our schools have advanced in costs several hundred per cent in the last few years because we have been glad to give schools everything asked for, but no one has asked for the health work in our schools.

I feel that it is time we go on record in demanding that this great loss of 24% of our school budget be made use of, that one hundred and eighty thousand dollars be added to the State Board of health's budget for full time workers specializing in work of correcting defects and malaria and hookworm work in schools during the school terms and general health work during the interim. This would give us a full time man in every county or a traveling clinic to work the counties in which the work is most needed, or give \$183,000 to get the benefits of \$8,473,763 which is lost from non-attendance.

Dr. G. H. Edwards, Orlando:

I was quite fortunate in having been able to read as well as hear Dr. Hanson's paper. As the conditions in Florida are tropical or near tropical in character, I feel that we are very fortunate in having as our Health Officer a man who probably knows more about tropical diseases than any other person in the State, and who is also an executive of unusual ability.

You either approve or disapprove his paper. If you approve his paper, I believe there is a way in which you possibly may help. The county health unit seems to me to be very essential to the welfare of this State. The scope of the Board of

Health will materially widen and its use to the county will have increased if they are allowed to become functioning units.

If you, as physicians and surgeons, have any contact with, or have in the legislature individuals whom you are treating or have been your patients, if you will contact with them and explain the fact that this is simply an enabling act, it seems to me that there is no reason why the county health units should not go over.

I thank you.

Dr. F. A. Brink, Jacksonville:

I would like to mention two or three little points, one of them being the requirement in the State of a Tuberculosis Hospital. Scarcely a week goes by that we don't receive one or more letters from interested people, charity workers, public health nurses, or others, asking what can be done to take care of a consumptive in the advanced stages without funds, living at home with family, wife or husband, and a number of children in a state of impoverishment. You have all perhaps come in contact with this sort of case, and been confronted with the difficulty of knowing what to do with such a patient. Probably your heart goes out to those little children and other members of the family who will later develop tuberculosis as a result of too intimate contact with this patient. In the past we have been compelled to refer these individuals to the county commissioners for charitable aid or to some local charitable organization. There has been a law passed in the legislature authorizing the establishment of a state sanitarium, and the money was to be provided, \$200,-000.00 per year for two years—\$400,000.00. A commission was appointed. That commission, so far as I know, has never even held a meeting.

There is another thing you doctors are interested in, or ought to be. If you want a tuberculosis sanitarium, one or more of them, in Florida, it is up to you to make a big noise and try to get it. This the State Board of Health and the Tuberculosis Association have made an effort to do. Florida is backward in that respect. It should not be. There is no need of being.

Another thing is the treatment of venereal patients. In other states the Boards of Health have arranged with physicians to contribute the expense for the treatment of indigent venereal patients. Treatment renders them non-infectious. It seems to be the general opinion that that is the best method of preventing the spread of venereal infections. We should like very much

to have enough money in the State Board of Health to buy drugs and supply them free to all physicians and even to city clinics when there are such clinics, to treat indigent venereal patients. But we have not the money. We do take a little out of the general fund and spend it for neoarsphenamin and send it out to physicians to treat one or two or a half dozen indigent patients for syphilis. But that is not enough. We should like to have a considerable amount of money to be used for that purpose.

Another thing, in regard to pellagra. The impression we have in the State Board of Health is that during the last two years pellagra has increased. You are all quite familiar with the relationship between the diet and pellagra, and I think you physicians can do considerable if you will let the people know what kind of foods are pellagra preventive and try to help the people and encourage them to provide themselves with that kind of food. We see so many rural homes in Florida with no cows, no chickens, and no gardens. These provide the three principal pellagra preventive foods.

I thank you.

ENDOCERVICITIS* W. M. ROWLETT, B.S., M.D., F.A.C.S., Tampa.

Infections of the cervix have for a long time been recognized as the most common disorder among women. In fact, so common are they that practically one out of every two married women who have borne children, have consulted and received neighborly advice relative to a leukorrheal discharge.

To accuse the profession of being amiss in educating the laity to the seriousness of such a symptom, or infection, is placing it mildly. To my way of thinking, it has reached the proportion of a gross neglect—a little too harsh, do I hear some of you say? Very well, then, how many millions of dollars have been spent in educating the people as to the importance of detecting the early symptoms of tuberculosis, and the many serious infections, or contagious diseases for which we are constantly alert?

Did it ever occur to you that the sight of many thousands of our blind children could have been saved had the mother had any way of knowing that her apparently harmless vaginal discharge was the result of a gonorrheal infection? Has it also occurred to you that cancer is increasing alarmingly, that the uterus is the most frequent organ attacked and the cervix the most common location? It is estimated that practically all of the cervical cancers are the result of a once curable cervical infection.

I wish also to call your attention to the multitued of women who are daily being operated upon for uterine, tubal, and ovarian trouble, being desexed—relieved in part or of all of their reproductive organs, as the result of improper attention to this apparently harmless cervical infection.

While endocervicitis is more general than the ordinary cold, it is potentially more dangerous than tuberculosis. Invalidism is often the result, and indirectly, the economical cost to the country is greater than any other disease of today. Yet, there is less publicity and effort to educate the people of this danger than of the common cold.

While much has been written about endocervicitis, the average physician seems to have a rather vague idea as to its course, dangers and treatment. Many still speak of it in such terms as cervical catarrh, cervical erosions, ulcerations, etc.

Such infective bacteria as the streptococci, tuberculi and the colon bacillus may be found. However, a great majority of cases are found to be of a gonorrheal infection, the gonococcus nesting in the cervical glands where it lingers with great tenacity, though, as stated previously, the endocervicitis may result from the non-specific infection resulting usually from the effects of child birth.

We may never be able to prevent women from marrying men who have had gonorrhea, but as physicians, we can advise the prospective husband of the dangers to which he is subjecting his wife-to-be and should he marry, impress upon him the grave importance of having repeated examinations made of her, for I feel confident that the large majority of men who have had gonorrhea, regardless of what treatment they have gone through, are gonorrheal carriers. I have had many histories of cases of gonorrheal endocervicitis, where the husband stated it had been from three to ten years since he had had the infection and had been given a clean bill of health by his physician.

The characteristic symptoms of endocervicitis are the tenacious, ropy, sometimes bloody, leukorrheal discharge, occasionally accompanied by backache. The cervix feels soft, spongy and slippery. Upon inspection, it is found to be red-

^{*}Read before the Central Florida Medical Society, Leesburg, February 27, 1931.

dish, swollen and dirty looking, being covered with a tenacious yellow mucous, and spotted with small elevated ulcers, that bleed easily upon touching them.

At the time of the examination we should be especially on the alert for the diplococci and treponema. If the tissue is suspicious looking, a specimen is taken for a biopsy. If our patient has given birth, we frequently find a lacerated cervix with eroded hypertrophied lips, dotted with nabothian cysts, and a granulating surface with a proliferation of cells. If this proliferation continues, with the breaking down of additional tissue, the constant irritation with its attending inflammation, we have a condition that plays a most important part in the development of cancer. Just how and what changes take place that produce cancer, we are not vet able to say, though we do know that cancer begins in a benign growth and is absolutely local in its beginning. Thus, all measures should be adopted to correct the condition in its incipiency.

Unfortunately, few physicians have the patience to treat locally, in their office, a case of acute, or subacute infection of the cervix. The nose and throat specialist will spend weeks or even months in treating an infection that can do far less damage to the health of the patient than an infected cervix or that of Skene's glands, and vet, on account of the unpleasantness and inconvenience of treating the latter, the physician contents himself by prescribing a simple douche, and that frequently, without an examination, while his neglected patient goes on, a silent sufferer, until the infection has reached such a proportion that she cannot longer endure it and the doctor is again consulted, whereupon he orders her to the hospital and subjects her to a major operation.

We are today much interested in preventive medicine, and if it were not that I feel that woman has not been permitted to fully share in this era of scientific medicine, I would not have devoted so much time to preliminary remarks. However, as stated in the beginning, when I see how little is being done to educate her as to the danger of a prolonged infection of her sexual organs. I seriously doubt if we have done our full duty. Take for instance, an old lacerated, eroded cervix which has developed into a precancerous condition. While we know the danger of this condition if permitted to go on untreated, we hesitate to speak of it to our patient as a precancerous condition, as we know it will carry terror to her heart.

James Ewing, Professor of Pathology, Cornell

University, states: "The great majority of cancer develops in organs altered by reactive inflammatory process, previous exudative inflammation often leaving tissue changes predisposing to cancer."

Arnold Sturmdorf, Professor of Gynecology, New York Polyclinic Medical School, says: "Chronic catarrhal endocervicitis precedes cancer in the great majority of cases and the cervical erosion is the most definitely established lesion known to initiate cervical carcinoma."

The American Society for the Control of Cancer states:

"One factor during the last ten years that has proven to be of great importance in the origin of cancer is the element of chronic irritation. As the various theories of the parasitic origin of cancer have been disproved, the element of chronic irritation has been found to become an increasingly important factor in the incidence of cancer in one region after another. This fact has made it possible to give prophylactic treatment for the purpose of preventing the occurrence of cancer. This prophylaxis further demands the avoidance of sources of chronic irritation, such as, for instance, the removal of an ill-fitting tooth plate which causes irritation of the gum, or the repair at as early a date as possible, of the deeper lacerations of the cervix which occur at childbirth. Infections and lacerations of the cervix of the uterus, the almost inevitable result of childbirth, are the most common factors predisposing to cancer of the cervix."

Palese has demonstrated that thirty-four out of forty-eight cases of cervical carcinoma came from infected, lacerated cervices.

Beckman has carefully observed the development of carcinoma in an erosion which he treated for five years.

Now it seems to me that the time has arrived when we should take our patients into our confidence and teach them something about this disease. In addition to this, there are a few important facts with which the profession must become better acquainted. As you know, a few years ago, dilatation and curetment was the most frequent gynecological operation performed; the scraping of the uterus to cure a case of chronic endometritis or leukorrhea had assumed the proportion of a fad, the fallacy of which is proven by our present day knowledge that there is no such infection as chronic endometritis, that the uterine canal above the internal os is practically infection-proof, and

that leukorrhea is of a cervical and Skene's gland origin instead of uterine.

Dr. Arthur H. Curtis, of Chicago, who has done more than any other man of our age along the line of investigating uterine infection, has completed a combined bacteriological and histological study of one hundred and eighteen uteri removed to remedy various pathological conditions, and states: "The body of the uterus above the level of the internal os rarely yields evidence of chronic infection."

The racemose glands which are found in large numbers penetrating the cervical mucosa which lines that canal, and are very susceptible to infection, can be aptly termed the tonsil of the uterus. These are mucous-secreting glands, which, after becoming inflamed, are stimulated to a higher state of activity. It is estimated by a prominent authority that the infected cervical glands, enmeshed with its great lymphatic system, is a greater hazard to the health of the woman than an infected tonsil is to a child: thus, chronic endocervicitis is not only the most prevalent gynecological disorder, but our patient may easily get from this a secondary infection that will menace the entire gynetic as well as the general system. Therefore, we cannot devote too much care in the examination of our patients who come to us complaining of the slightest abnormalcy about the pelvis, it matters not whether it be pain or a slight leukorrheal discharge.

Cervical lacerations after childbirth provide a most inviting field for infection, as the vagina is a site of numerous bacteria. Bearing this in mind, I always endeavor to repair all lacerated cervices at the time of delivery, making it also a rule to have my patient report at my office four weeks after the birth of her baby for examination, at which time a thorough search is made for raw and unhealed surfaces. If found, they are painted with ten per cent silver nitrate solution, and she is instructed to report every week until such lesions are healed. In the cervix, as elsewhere, infection incites the greatest reaction in its lymphatic system, in following the course of which I wish to quote Leopold:

"The infection may be traced through the lymphatics from its lacunar origin in the cervical and corporeal mucosa through minute funnel-shaped ostia directly to the myometrium; it branches into an extensive capillary net, which, spreading on the perimysium, penetrates and enmeshes every bundle and fasicle of the entire

uterine musculature to its subperitoneal surface, whence it traces into two main collecting canals that course parallel to the uterine and ovarian blood vessels at the base and top of the broad ligaments." Thus, the old theory that the infection traveled up the uterine canal to the tubes and ovaries is dispelled.

The treatment of endocervicitis differs according to the severity of the disease. In acute cases our efforts are bent on preventing the infection from extending into the deep glandular tissues of the cervix, where it becomes chronic and difficult to cure. These mild cases, with superficial infection, may be relieved by the application of a ten per cent silver nitrate solution every three or four days. I have obtained excellent results in the gonorrheal cases by following Kelly's technic, which consists of a bi-weekly use of a 20 per cent mercurochrome solution in the cervical canal as high as the internal os. In addition, he prescribes a daily hot vaginal douche with some good antiseptic solution. He keeps this up until three or four negative smears for the gonococcus, at monthly intervals, have been obtained. If there is a vaginitis accompanying the cervical infection, this must also receive attention. In my vaginitis cases, I have had the best results with ten per cent ichthyol glycerine tampons in conjunction with the above cervical treatment. The more severe cases, with deep glandular infection which may have existed for years, causing the ducts to become occluded and distended, resulting in a honevcombed cervix, riddled with many small abscesses, as a result of the occluded ducts, require more radical treatment than local applications. In addition to the general health, which in most of these cases require building up, there have been several treatments advanced, all of which have their advantages as well as their disadvantages. Sturmdorf has devised a tracheloplastic operation in which he removes the entire diseased portion of the cervix. This operation has given excellent results, though, on account of its large production of scar tissue and the destruction to the alkaliproducing glands, I do not consider it practical in a woman during the child-bearing age. Others have had very satisfactory results by the use of the electric cautery, taking a pointed instrument and making numerous punctures into the deeply infected cervix, or a cutting edge cautery making several deep cuts through to the diseased cervix from the canal outward. The heat destroys the infection and the punctures provide drainage

for the occluded cysts and blind abscesses. Care must be exercised, however, in using the cautery too freely in the cervical canal, lest we get a great amount of scar and a complete atresia. Radium has also been used a great deal recently in treating this condition. I have had very good results from the use of both the electric cautery and radium. My technic with the latter consists of fifty mgs. of radium in a brass container with walls one millimeter thick, this covered with one millimeter of rubber, and placed in the cervical canal for six to ten hours, depending upon the severity of the case and age of patient. Frequently, I take the same amount of radium in the irridium platinum needles and bury them in the diseased cervical tissue for the same length of time as above.

FOCAL INFECTIONS, THE RESULTING MORBIDITY AND TREATMENT FOR SAME

T. M. RIVERS, M.D., Kissimmee

Focal infection in medical parlance means infection localized in one part of the body, which infection produces morbidity in some other part of the body separate and apart from the infected area. The focus of infection may be within the tissues of the body, or it may be external to the body tissues but enclosed within some cavity of the body. The foci may be single or multiple and may vary much in size. It is the opinion of some that these foci are merely nesting places from which bacteria are picked up by the blood or the lymph and transplanted to other foci. This may really occur in some cases of focal infection, but this is not the true way in which focal infections, in the correct sense, produce their morbidity. Focal infections, in the exact meaning of the expression, produce a toxin in the infected foci, which toxin is carried by the blood and lymph to the points made morbid by it, or to the nerve centers controlling these tissues, and, by its effect on these nerve centers, causes the morbid condition through the action of these nerves. True focal infections are separate and apart from the tissues made morbid by such infections, but secondary infection may be transmitted through the circulation of the blood and lymph and, since such infection has special affinity for diseased tissue, it is the more apt to attack the diseased areas. The bacteria found about many diseased areas may be accounted for in this way when they were not present at the onset of the morbidity.

Bacteria. The bacteria of focal infections are conceded by most bacteriologists to be of the streptococcus-pneumococcus strains and, in most cases, they are of the less virulent strains of bacteria. However, we have no right to say that other bacteria are not found in focal infections. In fact, they are found in many cases and they may be the disease-producing agents in some cases. It is sufficient to say that no one strain of bacteria has been found constant in all cases of focal infections; but bacteriologists in most cases seem to have found the streptococcus viridans more nearly constant than any other. It may be that one kind of bacteria, as the bacillus of tuberculosis, starts a focus of inflammation and some other kind, as the streptococcus viridans, enters the focus secondarily, where it forms the toxins which are transmitted from the focus; or more than one kind of bacteria may be working in the same focus, both producing toxins at the same time.

Location. Perhaps the upper air-passages, including the mouth and the teeth, the nasal passages with their sinuses, and the throat with its tonsils and adenoids and eustachian tubes to the middle ears, are the most common primary foci of infection; but these are by no means the only points. Any tissues of the body may be primary points of infection. Secondarily, the infection may be passed by inspiration into the bronchial tubes to form nests in the walls of these tubes, or to pass deeper into the tissues of the lungs, or even to break through into the pleural cavities. Again, the bacteria of infection may be swallowed down into the stomach and pass on down into the meanderings of the intestinal tract, finding lodgement in stomach ulcers, intestinal ulcers, the gallbladder, the appendix, intestinal diverticula, or finally, into the colon where they may be retained in the pockets and folds indefinitely.

Toxins. The proteins of the body are made up of eighteen kinds of molecules, known in chemistry as amino acids, each protein having its own combination of amino acids. Each amino acid contains one or more carboxyl radicals, COOH, or carbon dioxide with a hydrogen atom attached. Whenever there is dead tissue in the body in the form of a dead tooth, cheesy matter in the crypts of a diseased tonsil, or exuded serum and fibrin in a diseased nasal passage, this dead tissue may become infected with bacteria which bacteria separate the carbon dioxide from the hydrogen atom of the carboxyl radical, changing the amino acid into an amine. The amino acid,

we must remember, is a necessary unit of food for the body; but the amine is not only, in most cases, abnormal to body tissue; but, in excess doses, it is usually toxic. The amino acids, we learned above, are eighteen in number, but these may be changed by decarboxylation and later by further chemical action into many amines. Each amino acid may be changed into its corresponding amine first by the simple process of decarboxylation, and these amines may be further changed by substituting alcohol radicals for hydrogen, forming secondary and tertiary amines, which process may increase the number of amines greatly. Amines vary in their physiological action toward the body and also in their solubility, some being more soluble in water and others being more soluble in oils. Absorption and transmission of these amines in the body may vary with their solubility in the adjacent body fluids. So the kinds of amines absorbed and passed into the body vary first with the amino acids converted into amines and then with the solubility of the amines in the adjacent body fluids. The amines being absorbed from any focus of infection, pass into the lymph or blood by which they are transmitted and brought into contact with some distant tissue, or the nerves supplying such tissue, which they damage by their toxic effect, producing the morbid condition of some disease.

Action of Amines on the Tissues. Professor George Barger of Edinburgh, who delivered some lectures at Cornell a few years ago, and his associates let fresh meat become infected with bacteria by exposure in the open atmosphere, and the infecting bacteria changed the amino acids of the meat into amines; and they extracted these amines from the decomposed meat. They tested the several amines obtained in this way on lower animals to determine the physiological action of these amines. They found that the action of these amines is much like the action of adrenaline, which may be considered a normal body amine, and that the amines with chemical construction nearest to that of adrenaline, as phenylethylamine and tyramine, approach nearest to the astringent action of adrenaline. Barger examined about forty amines and determined the physiological action of many of them. He showed how the length of the sidechain and the number of the carbon atoms in the amine molecule vary the physiological action of the amine. He showed clearly that each of the amines has its own specific physiological action. He discovered, too, that the amines may act by direct contact with the tissues, or they may act through the sympathetic nervous system, for which reason he and his associates called this sympathomimetic action. In testing the action of amines on lower animals, it has been found that tyramine and phenylethylamine, raise the blood pressure, while cadaverine and putrescine lower the blood pressure; that histamine lowers the general blood pressure while it increases the pressure of the uterus and the bronchial tubes; that indole and skatole lower the general blood pressure while they cause vertigo, nausea and vomiting; that, while indolethylamine raises the general blood pressure, it produces that irregularity of muscular contractions which we designate convulsions.

While Barger and his associates were working out the physiological action of the amines, Pemberton of Philadelphia and his associates were doing some wonderful work in the pathology of arthritis. Pemberton found that the morbid condition about the joints in arthritis deformans is due to a constriction of the arterioles about the joints, obstructing the blood supply to these tissues, which means insufficient nutrition to the arthritic tissues, and that all of the morbid conditions of arthritis can be due to this deficiency of nutrition. Bacteria cannot be found about all of the diseased joints and he states that the morbid conditions about the joints could not be accounted for by the direct action of bacteria if they were present in these tissues. He attributes the morbidity of the joint tissues to something done or produced by the bacteria in the focus of infection but he does not know how this is done. Several other authors seem to be unable to find bacteria in all of the diseased joints and are unable, too, to account for the morbid conditions through the action of the bacteria in the foci of infection, although they all agree that the bacteria in the foci of infection are the cause of the disease. They practically all admit that there is uncertainty as to the relation of the bacteria in the foci to the morbidity of the joints.

Getting the idea that there might be some relation between Barger's pressor amines and Pemberton's narrowed arterioles about the joints in arthritis, we began to make such investigations as we could with our limited means. We got the idea that, if meat infected with bacteria by exposure in the open atmosphere had its amino acids decarboxylated into amines by these bacteria gathered from the atmosphere, the same thing could happen in the human body. We took different foods from the table where they were prepared to eat. We secured specimens of infection

from apical granulomata of teeth, cheesy matter from the crypts of diseased tonsils and fecal matter from persons suffering from some form of arthritis. From these we made cultures in meat, milk and potatoes, running controls at the same time to make sure of the difference in results. We obtained frogs and turtles and guinea-pigs on which to make our tests. We observed the web of the frog's foot normal under the microscope and then swabbed and soaked it in our culture broth. The first reaction was an increase in the blood-flow as indicated by the more rapid passage of the corpuscles through the tiny arterioles. This was probably due to the irritation in applying the broth. Soon this first reaction was followed by a narrowing of the arterioles which was certainly due to the astringency of something in the culture broth. The control broth gave no reaction. That the difference was the amines in the infected broth can hardly be questioned. Its action was much like that of adrenaline solution in blanching the tissues. Next, we tested our broths on our turtles. (Here we will say that the turtle is a very valuable animal for these tests because its heart will continue to beat some time after it has been removed from the body). As we opened the bodies of the turtles we tested our broths by injecting about any bleeding points and observed the astringent action. When we reached the heart, we cut some small vessels and observed the astringent action by injecting our culture broth near the vessels. We tested our broth by injecting into the tissues of the heart and observed the astringent action. Our controls failed to give any reaction in any of these cases. In all of our tests above, the meat cultures gave the greater reaction, but we think this was partly due to concentration. Finally, we made some tests on guinea-pigs, but owing to the lack of proper laboratory equipment and definite time for care and observation of our pigs, our tests were unsatisfactory and without any definite results.

Combining the results of our tests and our clinical observations with the knowledge gained by others, we are convinced that amines may result from decomposition of body tissues, as at the roots of dead teeth, or from the cheesy deposit in the crypts of tonsils, or from the serum and fibrin of the catarrhal exudate in the air-passages, or from the decomposition of remnants of undigested food in the colon, just as Barger's amines resulted from bacterial infection in the open air. This undigested food becomes of vital importance when we observe the different actions of the sev-

eral foods tested. We are, furthermore, convinced that there are several of the worst maladies which we, as physicians, have to treat which may be due to the pressor, or depressor, action of these amines. In working these things out, we have compared them with our clinical experience and find that we can make direct application in many cases. Therapeutic tests give like results. We have compared our laboratory observations with cases of arthritis deformans, angina pectoris, mitral disease, and chronic hypertension as well as chronic hypotension and find that both clinical and therapeutic tests corroborate this theory of amines as one of the major etiologic factors in these diseases. The several amines resulting from decomposition within the body have separate and distinct actions on the various tissues of the body just as other therapeutic agents like digitalis, ergot and opium have distinct actions. In some cases this may be a pressor action on the coronary arteries of the heart. An astringent action on the coronary arteries can produce the symptoms of angina pectoris. We have found that some amines have this action, and we have satisfied ourselves by clinical application of this theory in modifying the diet to one of low calories, which would result in few amines absorbed from the colon, that this is one of the major causes of this disease. We observed that the astringent action of the sympathomimetic amines injected about the heart would distort that organ enough to vary the action of the valves, the same thing which happens in mitral disease, and we have been able to modify the severity of mitral disease by removal of a focus of infection and a diet low in calories. Chronic hypertension, or high blood pressure, that great dinosaur of the present age, as most of us know, is modified permanently more by a diet low in calories than by any remedy listed in the pharmacopœia; and, when we learn to look for the foci of infection in these cases and eliminate them, we will have made much greater strides toward the permanent relief of this very common morbidity. Combining the findings of Barger and Pemberton with the results of our investigations, we are convinced that amines resulting from focal infections may be one of the major causes of arthritis deformans. Dr. Allan Eustis of New Orleans found some cases of asthma due to histamine which has direct pressor action on the bronchial tubes, and we believe that we can show that many such cases are due to this cause. Some cases of dysmenorrhea and amenorrhea are probably due to histamine from focal infections since it is one

of the active principles of ergot and has been proven to have direct pressor action on the uterus. Comparing our laboratory results and our clinical and therapeutic observations with the findings of others, we are convinced that amines from focal infections may satisfy all of the etiologic conditions in the diseases named above. Our theory would extend to several other diseases which amines probably may cause. The tiny muscles moving the bones of the internal ear could be rendered morbid by the pressor action of amines, which could be the cause of Menierre's disease, a disease the cause of which has been unknown to us. Raynaud's disease is certainly due to the astringent action of some substance, and amines from focal infections fill all of the requirements of such substance. Several diseases of the eye are due to disturbance of the tiny involuntary muscles of that organ, and amines have just such action as would cause such diseases. Some skin diseases may be accounted for, too, through the morbid action of amines. These amines act in combinations varying in kind, quantity and the susceptibility of the patient. The field is almost unlimited and we have just entered one corner. When our expert chemists, physiologists and pathologists, all working together, determine the exact physiological action of each of the amines derived from the amino acids of the body, this part of the practice of medicine will have become a more nearly exact science.

Treatment. Like other diseases due to infection, the first and foremost thought in treatment is that of prophylaxis. That the amines may be absorbed from the intestines is evidenced by Underhill of Yale and others. That they may be absorbed from other foci can hardly be questioned. Relief from eliminants is uncertain and temporary till the focus of infection is removed, remembering that if the primary focus is in the upper airpassages and these have been draining, a secondary focus nearly always exists in the alimentary tract, which must have attention as well as the primary focus. The sooner these foci of infection are located and disposed of, the milder will be the diseased condition to be treated. When proper treatment is carried out early, recovery should be more nearly complete; but it is still beyond medical skill to restore perfect function to ankylosed joints or distorted heart-valves or calcified arteries. The symptoms may be much modified but perfect cure is uncertain. Treatment before these morbid conditions have developed is much better. We have our school-nurses and our free clinics through our departments of health to examine the children and report their irregularities of body: a most wonderful arrangement which should be pushed forward both for individual benefit and for community welfare. Let the children be taught from infancy the danger of these foci of infection and how they may free their bodies from such dangers. For older people, each one should select for himself some reliable physician whom he should consult at regular intervals and have these foci of infection located before the later morbid conditions have developed. Early diagnosis and removal of some focus of infection may mean the difference between an invalid and a person of health, useful to his country. All questionable tonsils should be removed. The retention of a dead tooth is a dangerous venture. Diseased sinuses and diseased genitourinary tracts should be healed. All points of pus-formation should be opened and drained. Let us understand that the draining abscess is much less toxic than the tiny hidden smoldering abscess from which all of the toxins are being absorbed. Constipation should be corrected for it is from this focus that many of the worst chronic cases are fed. Remember, too, that colonic irrigations are sometimes better than protracted use of cathartics. Find the focus of infection and remove it.

Next to removal of infection comes diet. With our present knowledge of the source of amines from protein foods, it would seem that all proteins should be eliminated from the diet; but this is not true. Proteins should be reduced to the point where there should be little residue left unabsorbed to pass into the colon. Let us remember that the proteins which are digested and absorbed are less liable to do harm. It is only the residue which passes into the colon which is attacked by bacteria in this focus to form the toxic amines. For this reason the diet may sometimes require limiting in proteins. Something else should be observed in regulating the diet of persons suffering from the sympathomimetic diseases. Many times we find that the carbohydrates are more harmful than the proteins. The reason for this is explained by Pemberton. He shows how the toxic agent narrows the arterioles so much that the blood cannot reach the tissues properly to utilize the carbohydrates, and this causes retention of blood-sugar. All of this could be summed up in saying that the diet should be limited in calories. Persons suffering from the sympathomimetic action of amines should live as nearly as possible

on fruits and vegetables. Sometimes we find ourselves between Scylla and Charybdis when the focus of infection is in the lung. Certainly, we would not limit an emaciated tubercular subject in diet to try to overcome some other morbid condition.

Exercise or rest, ultra-violet ray, autogenous vaccines, electricity and non-specific proteins are all advocated by some, and all probably have their places in the treatment of these morbid conditions. Their application depends on the condition to be met.

Medical treatment is entirely symptomatic. Permanent cure is hardly to be expected so long as the toxins are pouring in from the source of infection. When the focal source is removed, the toxins may clear up in a short time in those of strong constitution without any medical treatment. However, eliminants may serve to aid nature in the process of elimination. For the greater pressor diseases the vaso-dilators may be of some benefit. After the source of infection is removed and convalescence is established, codliver oil with moderate exercise in the sunshine may be an aid to nature in readjustment of calcium and phosphorus, which have undergone malassimilation. Many drugs may be of service as the conditions arise for their use. Each of these kindred diseases requires some special treatment besides the general suggestions given here. Idiosyncrasy has much to do in the course and severity of these diseases, and the endocrines of the body probably modify the course.

Some of the amines are already being used in medicine and it is possible that we may some day develop an amine treatment for the morbid conditions caused by amines, using the depressant amines to counteract the pressor amines and vice versa. In that way we could utilize the physiological action of the one amine to counteract the morbid action of the other.

Finally, we realize that some of our statements in this paper are new and probably may be questioned; but the statements are all made after due study and investigation, and we invite proper scientific investigation and criticism, for this is the best means by which truly scientific facts are established. BIBLIOGRAPHY

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WITCH DOCTORS AND THEIR PRACTICES

D. W. McMillan, B.S., M. D.,

Pensacola.

Although I am greatly appreciative of the honor done me in the interest manifested for my subject, it is with trepidation that I stand before you. since my paper does not treat with science, but



merely with the superstitions and primitive mode of healing, as is practiced by the African Medicine Man, as I have known him. Gentlemen, I beg your indulgence for only a short while.

The fear of disease is one of the strongest emotions known to men, for it may usher death, particularly in primitive lands. It is then only natural that the art and practice of medicine in tropical Africa should fall into the hands of the priests and wizards of the various prevailing cults.

At present, there seems to be a revival of interest in everything relating to the so-called Dark Continent. At any rate, ethnology has taken a forward step in that direction, and we physicians are curious as to how the natives take care of their physical and mental ailments. Of course, there is an enormous deal known about tropical medicine. It will not be my business to treat of matters which can be found in text books, but rather to dwell on conditions that are primitive.



Jungle land, as you know, is an infamous region for the white man. It is not merely the fever, the sun heat, the wet weather; it is all of these disadvantages and more. Sunlight may be wholesome in moderation, but here the sun rays sap life and energy and weaken the ill-nourished blood. Besides, the water is indifferent, even to wash in; it is of every color and consistency; of foul odor, and to drink it is pretty risky even for the blacks. It must always be boiled and filtered.

Always there to annoy is the mosquito and blood-sucking flies, the tsetse, mango and tumba flies and the chinaka, a tiny fly which wanders over the skin, leaving a burning trail, even on the skin of a Negro. With all these pests, in addition to scorpions and snakes (from which, strange to say, the native mortality is not heavy), the Negro mind is in a state of anxiety as to when he will be taken off, and he demands protection from unknown ills through witchcraft medicine.

Let us, as physicians of 1931, not be so swept by the glamors of industrialism or the fires of bigotry that we fail to take note of men's souls. There are some gifts after all, some allied to the divine and spiritual, which are in the hands of the black race, which has so long yearned and suffered. They are not absolutely an inferior race, though they have to be uplifted eventually, if they do not learn by their own experience. If the natives are superstitious, many whites are equally so, in other ways, though much the Negroes think and do is pagan and heathenish.

The great forests and mountain haunts abound to the Negro with spirits capable of doing harm, and so everyone must be on guard. A charm, an amulet, words for repetition to disarm the mysterious power are needed, and the witch doctors are there in great number to supply these. Any man may have some such objects for his help, may know some such protecting lore. It is the witch doctor, however, who has from childhood made a special study of spirits and the mode of dealing with them.

These fetishes are supposed to possess an inherent virtue, which is magically active by reason of its association with spirits.

As a rule, the calling of a witch doctor is hereditary, although under special circumstance novitiates may be enrolled from among outsiders. They are divided into classes. Some claim to control the seasons, to bring down the rain in torrents or to bring droughts. All work hand in glove, making a pretense of blaming each other, should a demonstration of their power be a failure.

The witch doctor may pursue quite ordinary avocations until called upon in a professional way; then he adopts a solemn aspect and wild attire, skins and claws of wild animals, feathers, beads, strung shells and a weird head-dress.

The witch doctors are looked upon with respect and awe, and their instructions are carefully followed. Like us physicians, they do not always believe in their own powers; however, they will admit this only to a stranger. They play upon the superstition, ignorance and credulity of their people and surround every aspect with a cloud of mystery. They include in their pharmacæpia herbs, roots and the excretions and venom of

snakes, rendered harmless by incineration. If they fail, they ascribe it to God's will, evil spirits or a violation of terms of the taboo. The witch doctor is very superstitious and jealous of medical missions and hospitals. He exercises a vast control over the natives, because they alone are supposed to know the laws which regulate the spirit from birth to death. They can either drive evil spirits away or summon them from the deep.

In certain parts of Africa, the witch doctor is easily the most powerful individual. All the native chiefs, sub-chiefs and the people under them fear him, and will do almost anything in order to keep in his good graces. A native, who is accused by a witch doctor of causing the illness or death of some other person, will usually admit that he is guilty, since his admission will bring upon him a milder punishment than would be the case if he denied the charge.

It is a disputed point as to just how much a witch doctor believes in his power to communicate with the spirits of the departed. He is a very shrewd man and knows well how to work upon the superstitions of the people. His living depends upon his success in his calling. He probably knows very well in most cases that he is simply deceiving the people. By this statement, I do not mean to say that he does not usually, or at least often, discover the guilty party in many cases of wrong-doing. He knows full well the truth of the saying, "murder will out." He is quick to weigh and give proper significance to every bit of evidence which comes his way. He is good at



character reading, and soon detects guilty looks in the faces of those who are brought before him.

There is no doubt that in the poison ordeal, in many cases, the guilty party suffers as much or

more from his guilty fears as from the potency of the poison which he is given to drink.

On the other hand, there is plenty of evidence to prove that the witch doctor very frequently declares innocent the person who has paid him the largest fee, and pronounces guilty the one who has paid the least or who is most unpopular among the assembled people. He is quite quick to take a lead from the ejaculations or other evidence of approval or disapproval of the people. He has many ruses to which he resorts in proving who is the guilty party.

For instance, a hoe is heated in the fire. If he wishes to prove a man innocent by the fact that the hot hoe does not burn his hand, he harangues the crowd with the hoe in the air until it has cooled; with the one whom he wishes to prove guilty, he speaks only a few words and hands the hoe over quickly, while still hot, to the person to be tried. He may put a number of sticks in holes in a board. Then he hands a stick to each person to be tried and tells each one to hold the stick in his mouth while he is addressing the people. These sticks are then put again in the holes in the board. Later each person is told to take out his stick. If it comes out, the person is innocent. If it sticks fast, he is guilty. He has taken pains to hand to the one whom he wishes to prove guilty a stick made of a wood which very quickly swells, and, therefore, it becomes stuck fast in the board.

Another scheme, when giving poison to people who are suspected of guilt, is to put poison into a very small goat horn, then to put this horn inside another horn in which is some harmless mixture. He then hands the one who is to be proven guilty some of the poison from the concealed horn, while he gives some of the harmless stuff to the others who are being tried.

There is no doubt that many people have great faith in the witch doctor, and that he is the means of bringing about the recovery of sick people. It is a common belief that sickness is the result of transgression of some moral law. The sick person confesses his guilt to the witch doctor and becomes free from his guilty conscience, and then recovers through his own faith that he will get well.

When a witch doctor is summoned to the bedside of a sick person, he begins by asking the sick person if he knows the cause of his illness; if he thinks that a certain enemy has caused him to be possessed by an evil spirit, or if he has been guilty of some grave sin or immoral act which would likely anger the spirits. If he can get no evidence in this way, he will proceed to determine the cause by throwing the bones. These consist of a collection of various articles; special bones of animals, certain sea-shells, carved pieces of wood, etc. These he holds in his hands and lets fall in a heap on the ground in front of him. He reads from the relationship of these articles, as they fall together, the answer to his questions. As he lets them fall, he puts a question to the spirits: "Why do you trouble us at this time?" No answer. "What do you want? Have we angered you?" "Yes!" "Whose ancestral spirit are you? Do you come from such and such tribe?" "From such a tribe?" "Oh! What shall we do to make this woman well and be troubled no more? Do you want a girl as a present?" "No." "A cow?" "Yes." "Who sent you here? Did so and so? Then so and so?" Each time he stops to study the bones and read the answer. Afterward the necessary present is produced and given to the witch doctor, who, of course, claims possession.

Any person declared guilty of causing the spirit possession is sought out and punished. Then the tom-toms will be beaten perhaps for several nights and days, without intermission, in order to drive out the spirit. Imagine the effect upon a person weakened by fever!

A new-born babe refuses to take the breast. The mother, in fear, recalls some sin which she has committed. She cannot even attempt to get the child to nurse because of her guilty conscience. She confesses to her husband, or to the witch doctor, and then the child begins to nurse.

It is a popular belief that no sickness occurs excepting through spirit possession. The spirit which is angered has to be appeared. Perhaps the person who becomes ill has forgotten to make a thank-offering for a bountiful harvest. The spirit may be cold because no cloth has been set aside in the house for it. Some enemy may have sent the spirit to make trouble, or any of a thousand things may be at fault. The witch doctor has to be consulted. He will throw the bones and tell what must be done to appease the spirit. Some charm must be worn, such as a piece of python skin in which is wrapped a bit of bark, some certain bone of an animal or a certain kind of seashell, etc., etc. It may be necessary to have certain lines cut upon the weapon which the person carries, or it may be that some guilty person must be smelt out and punished. After an epidemic of influenza or smallpox, the witch doctor must be consulted and the guilty party determined and

punished for each death which has occurred. No one thinks of taking a long journey or doing any unusual thing without consulting the spirits of his ancestors. This must be done through the witch doctor.

From what has been already said, it will be seen what comprises some of the things which are used for curing disease. There is thought to be great efficacy in many kinds of charms, or fetishes. This word comes from the Portuguese fetiso, a talisman or charm. A piece of grass is tied about the waist or about the wrists; certain beads about the neck; red clay in the hair or even smeared all over the body. Lines shaved in certain directions about the head, many kinds of bones of animals and sea-shells; a certain thorn placed at the door of the hut will keep out wild animals. A certain plant is used to make the dog proficient in hunting down game. Another plant is used to prevent lightning from striking the hut. Peanut shelis placed at the fork of the road outside the village



will insure a good crop next year. At many rest places along the paths, a passerby adds a stone to the pile which is accumulating there. If one is likely to arrive at his own or another village too late for the meal, by tying the grass by the road-side as he walks along, he can keep the pot from boiling too quickly and thus will not lose his meal.

Then there are certain omens which forebode trouble. A man starting on a journey will return and wait until another day, if he sees a bushbuck cross his path ahead of him, or if a baboon sees him and does not call out.

There are quite a number of simple remedies which are known to others than the witch doctor. Those who know of them either sell them or even give them to their friends, but usually they do not tell what they are or where they are to be found. Certain simple remedies are used by the natives such as licorice, ginger, the bark of the red

mahogany and other trees for colds, diarrhea, dysentery and influenza. Certain medicines are carried to prevent snakes from biting, and others which are claimed to cure one who has been bitten, even though he may be already unconscious.

There are various stimulants used by Negroes which cause them to gratify the senses immoderately, when they are under the influence of a pathological condition. Several elixirs are in common use, made by boiling the inner bark of a dark colored tree. The effect of the drug is to put a man in a waking trance, a state interrupted from time to time by outbreaks of buoyancy. It also causes temporary loss of memory.

There is a certain bulb which the people commonly use as an aphrodisiac, especially just after marriage. One young man was apparently given an overdose of this remedy, and he became raving mad. The attack lasted for a day or more. I suppose he was unusually susceptible to the remedy, or else an overdose was administered by mistake.

The witch doctor has many remedies which he uses in his practice. He claims that the spirits show him where to get these remedies. A young man acting as porter to our party was just beginning to commune with the spirits. Two of us had left the camp in the morning with this man and another young man for a tramp through the bush. We halted at noon for lunch on the banks of a stream. The embryo witch doctor soon crossed the stream and disappeared. Half an hour later, we heard a great splash in the stream, and then something approached us through the reeds and made a great noise as it broke through them. We jumped to our feet, wondering if a buffalo or other beast might be coming, when this man appeared before us with wild eyes and trembling body. He had a considerable number of roots, freshly dug, on his back. We asked him what was the matter. At first he did not seem to notice our presence. He sat down nearby, making no reply to our questions. I asked him where he got the roots. "I do not know," he said. We could get no other response. Then I told him to throw the roots away and come with us. After some hesitation, he said that he would prefer me to throw them away. I picked the bundle up and threw it into the reeds. He began again and said, "You trouble me." He made no further remark during the twenty minutes back to camp. On our arrival, he sat down by himself, not entering at all into the general conversation of the other porters for half an hour or more. The next day he was himself

again, and we heard nothing further of the incident. The witch doctors say that they have no memory of having dug the roots or other substances which they use. They say that they just come to themselves and find that they have them.

While the bush Negroes have no idols, they do propitiate spirits with offerings. The silk-cotton tree and another they call kato are considered to possess evil spirits, that avenge any injury done them. For some reason, the boa constrictor is revered because it sheds its skin and seems to constantly renew its life. Snake-cut is a medicine made by wizards, taken internally or externally, which renders poisonous snakes unable to strike. It is taken as a prophylactic three or four times a year. No one knows exactly how it is done, but the traveler knows that everyone uses it. Snakes won't bother if you take it, and if you have a really good dose, snakes will be rendered helpless if they come near. Nevertheless, snakes do considerable harm and various preparations against snake bite are the property of the witch doctors who are, however, notoriously reticent.

They say that in German East Africa the Europeans have tried for a long time to find out the remedy of the Wahehe tribe against syphilis, a cure which is at least outwardly wonderfully effective. Many secret medicines exist among the African tribes, without doubt. The native pharmacopæia comprises many efficacious remedies for all kinds of diseases. Many of these preparations will not stand investigation, though where medicine has been practiced for so many untold years in the native wilds, it stands to reason that some of them are efficacious, and some day more will be known if the witch doctors can be prevailed upon to tell all they know.

Hans Coudenhove, in this connection, reports that one day a man came to him and stated that his wife had been bitten by a snake. A strong solution of potassium permanganate was given him, but it was not used. A few days later the Negro reported that a witch doctor he knew went into the forest and got some herbs. "These he chewed, and then he let the saliva drop into the wound made by the serpent's teeth, and she soon recovered."

The authors of "The Great Plateau of Northern Rhodesia" report one interesting point, which apparently bespeaks immunization against the spirillum fever tick, although they are not prepared to vouch for the fact. Some of the Angoni tribesmen have by repeated attacks in generations

past become immune, and in order to preserve this immunity when traveling, they are said to carry home-bred ticks along with them. This may seem rather fantastic.

Negroes are quite indifferent to vermin, lacking notions of hygiene and sanitation. It is for this reason hard to treat ulcerous and skin troubles, for they will wash off the ointment or put dirty hands on their sores or wounds. Many are great bathers and will duck into a stream several times a day.

Many natives will come to the white man's hospital doctors for the cure of disease in preference to their own medicine men, but they do not like to stay in the hospital for fear they are being experimented upon, or may have a limb cut off or like prospect, and so endure much suffering for their fears. Native medicine men charge high for their services. They declare that if the patient fails to pay the fee, the cured patient will fall sick again, and then if he refuses to pay up will in the end die.

When a person is sick for some time, he is supposedly beset by an evil spirit or chihamba. His name is frequently mentioned, and he is requested to leave the body of the sick person. According to authority of J. L. Keith, the chihamba is described as being like the wind and is liable to attack anyone at any time. After such infection, the person is attacked with rigors.

To exorcise the spirit, the witch doctor, or the village chimbuki, organizes a dance party, and the patient is left in the hut of the village. After the dance, the participants rush back and seize the patient, put him on a mat and wash him with a lotion prepared by this village chimbuki or doctor. After much song and music, the patient is removed from the hut, which is left behind, and apparently the evil spirit remains with it. The root of a tree, called by the natives "mushambizhita," is cut, dried out and put into water with some of the bark, and the patient washed in the concoction.

There is little doubt that a majority of the natives, comprising many millions of Negroes of all classes and of all tribes, have a great deal of faith in witch doctors, believing that they are the direct means of bringing about the recovery of sick people. It is a common belief that sickness is the result of transgression of some moral law. The sick person confesses his guilt to the witch doctor and becomes free from his guilty conscience, and then he often recovers through his own faith, or through the healing offices of nature let alone.

There are quite a number of simple remedies which are known to other than the witch doctor, and secrets are made of them. Assuredly for tricks that are vain and always full of guile, you can't beat the heathen witch doctor. He is a very shrewd man who lives on the superstitions of the people, who know very well that he is in most cases simply deceiving the natives. He is good at character guessing and soon detects guilty looks; is quick to weigh every bit of evidence coming his direction. He is full of ruses, deceptions, trickery and all the embodiments of underworld philosophy, and knows pretty well the uses of various potent poisons, which the forests of Africa supply in limitless quantity.

GRANULOMA INGUINALE* F. E. Daves, M.D., Chattahoochee.

This condition has been believed to be exclusively a tropical disease, but recent studies show numerous cases in the temperate climates with many reported cases of the disease which could not be traced to a tropical infection. The first complete description of the condition was given by Conyers and Daniels in 1896. In reviewing the literature, it is found that this condition is common in the West Indies, West Africa, some parts of South Africa, India, South China, and Northern Australia. A few cases have been reported from Europe and North America. This condition was first observed in this country by Summers and Frost in 1920, who recognized the bodies described by Donovan in 1905, which are pathognomonic of the condition. It is evidently endemic in the temperate zone of the United States, and occurs almost exclusively among the negro race affecting both sexes and is more common in the South than in the North.

Etiology: The etiology of granuloma inguinale is still unsettled. There have been many excellent bacterial studies to isolate the causative organism. Inoculation of cultures of the organism in the monkey, rabbit, and man, produces an abscess, but not a lesion, resembling that of granuloma inguinale. However, vaccines made with the bacillus do not cause any improvement in the condition. Various organisms have been found among which protozoa-like bodies (Donovan, Carter), a few kinds of spirochetes, one resembling the spirochete pallida, and various other

^{*}Read before the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, Chattahoochee, Oct. 9, 1930.

organisms have been found. Several authors believe that the various shaped bodies dscribed by different observers are differences in the shape of the same organism. However, it is now generally accepted that the "Leishman-Donovan bodies" are the causative factors in this and other kindred ulcerating conditions. In a case recently seen by Gaskill they were not only developed in pure culture but the lesions were reproduced in the guinea pig. Therefore, the exact cause is unknown. The question is still unsettled but for our purpose the finding of the Donovan bodies means that the patient has granuloma inguinale.

Symptoms: The symptoms are purely local. The effection begins as a papule or small nodule in the male, generally at the base of the penis, and in the female, usually on the labium minus. The growth extends toward the inguinal region and the perineum; new papules and nodules developing without deep ulceration, as a rule, but with a thin offensive discharge. Here and there may occur patches of dense scar tissue; the effection is not usually painful. There may be a slight itching or a burning sensation present at times. There is a scanty exudation on the ulcerative surface, which is mucoid in character; at times odorless, again may be very offensive.

Diagnosis: Briefly, I will state that its diagnosis is dependent on (a) the characteristic local lesion; (b) the marked predominence in the negro; and (c) the finding of the specific organism originally described by Donovan. Wassermann tests have been negative with a few exceptions where undoubtedly a double infection has been present, and in these energetic anti-luetic treatments have been devoid of effect upon the granuloma.

Differential Diagnosis: The disease has been confused with syphilis, tuberculosis, epithelioma, and yaws. It is differentiated from syphilis by the absence of history or other signs of the disease and by the absence of positive blood serology. In case syphilis coexists, the differentiation is made by the unresponsiveness of the lesion to antisyphilitic therapy; from epithelioma, by the examination of small pieces of excised tissue; from tuberculosis, by the organism of Koch, tuberculin reaction, animal inoculation, and other signs of tuberculosis. The geographic distribution is an aid in differentiation from yaws, which is seldom encountered elsewhere than in tropical and subtropical climates. The lesions of yaws may appear on any part of the body, whereas granuloma inguinale is usually limited to the genitals and groin.

Treatment: Treatment with tartar-emetic in-

travenously acts as a specific, and rapid healing may be expected in most cases with the prompt disappearance of the specific organism. In fact, no other successful method of treatment is known. Treatment may be begun with 2 c.c. of a one per cent solution in distilled water gradually increased at intervals of 3 or 4 days. A 5 c.c. may be given at a single injection, to be repeated as often as necessary. Care must be taken not to sterilize the solution by boiling as tartar-emetic is decomposed by heat. Deaths have been reported from the use of antimony. Crevin in 1568 wrote that there is no drug with which one might more secretly poison a man, and the students of Heidelberg were required at one time to take oath never to use it. Randall reports renal irritation following the administration of tartar-emetic in 2 cases of his series. This drug may be given in amounts as high as 20 c.c., although such a dose may produce emesis; a variable shock reaction or marked shoulder pains as was demonstrated in our case. Several authors report renal irritations, pains in the long bones, rheumatoid in character, following the intraveneous administration of the drug.

CASE REPORT

The clinical history of the patient forming the basis of this report is as follows:

The patient, F. W., age 28 years, colored male, was admitted to the Florida State Hospital March 13, 1929, complaining of an ulcerating sore involving the scrotum, penis, and inguinal regions. The history was that he had always enjoyed good health until January, 1921, when a little pimple about the size of a field pea appeared just above the pubic region; in about 3 weeks the penis and surrounding parts were swollen and a number of pimples began to appear, the eruption spreading into the surrounding tissue. He consulted a physician who incised the area and gave him gtts. to take. Various treatments by different physicians were instituted, but the condition continued to grow worse, while the ulcer spread gradually. Finally, as result of irritation from his clothes he began to have pain and discomfort and was unable to work. Soon afterwards he entered a private hospital where he remained 90 days without apparent benefit. While there, he contracted the morphine habit. After returning home and not being able to obtain enough morphine to satisfy his desire, he gave himself up to the State authorities, who had him committed to the State Hospital for treatment.

Upon admission the physical examination re-

vealed a well-developed and nourished colored male, practically normal, except for a large wedgeshaped ulcerated surface covered with granulating tissue, involving the scrotum, penis, and inguinal regions, upon the base of which was a fibrinous exudate. The temperature was normal; pulse 78; respiration 20. Hemoglobin 80 per cent; red blood cells 4,200,000; white blood cells, 8,500; polymorphonuclear 70; lymphocytes 20; large lymphocytes 4. Transitionals 1; sugar, negative; blood Wassermann, 4 plus; Kahn, 4 plus; C. S. F., 4 plus; cell count, 14; Donovan bodies, positive; urine, specific gravity, 1,018; acid reaction; trace of albumin; few white blood cells. Upon admission the wound was cleansed and the ordinary antiseptics were applied. A few days later the local condition was diagnosed as granuloma inguinale.

Scrapings of the ulcer were taken from which a smear was made, demonstrating Donovan's bodies. On the following day 10 c.c. of one per cent solution of antimony and potassium tartrate (tartar-emetic) was given intravenously, but no reaction followed. The same amount was given at 3-day intervals until a reaction from the drug began to appear. Very soon improvement was noted as the ulcerated surface had decreased. At present the ulcer is about ¼ its original size. Scar tissue makes up the entire area with few scattered areas of granulating tissue and there is a beginning return of pigmentation, formation of scar tissue, with contraction of the whole area and

shortening of the penis. The giving of the drug never produced a reaction until he had received about 40 10 c.c. intravenous injections, following which he had severe headaches and pains in the joints, especially of the shoulder joints. The pains remained for a few days, and then disappeared. Again after the last dose of a series of 10 c.c. intravenous injections, a similar reaction occurred and it was decided the dose was too large; since then he had been receiving smaller doses with 2 weeks intervals; hence, there has been no reaction.

COMMENT

- 1. Granuloma inguinale is becoming more common in the temperate climates and is not looked for in the tropics as was done formerly.
- 2. A careful study of all ulcerations about the genitals should have scraping made to determine the presence of Donovan bodies.
- 3. Granuloma inguinale may be a mixed infection having associated with it chancroid, tuberculosis, or syphilis. The latter was true in the case reported here.
- 4. Granuloma inguinale is never associated per se with general adenopathy.
- 5. No other successful method of treatment is known other than the administration of antimoni et potassium tartrate.
- 6. Large doses may give emesis, joint pains especially in the shoulders; renal irritation and sometimes even shock.

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THE ANNUAL MEETING

There is in the minds of many a growing conviction that the annual meeting of the Fiorida Medical Association is not fulfilling the requirements of the majority of the members. Following the lead of many of the educational institutions, this Association, as well as many others, has allowed its program to become too scientific. While in no way wishing to belittle the scientific advances, it still must be borne in mind that the average practitioner cannot bring most of these scientific advances to his patient and if he could

he would not have the time to perform them. The general practitioner needs to have brought up for his discussion the problems that he meets in every-day practice; he wants his clinical skill improved in order that his bedside diagnosis and treatment will be of the greatest benefit to his patient. When the leaders of the Florida Medical Association prepare their papers, this must be emphasized and they must discuss the common problems for the benefit of the majority of the membership and not the rare case for a few.

Furthermore, it seems as if too little time is given over to the local problems of this State. There are health conditions peculiar to Florida that should occupy part of the time. Then the questions of medical licensure, advertising and quacks should be given consideration; more than the component county societies—can give them. The Florida State Board of Health and the Florida State Board of Medical Examiners might receive considerable benefit from the profession as a whole. These two boards should be an integral part of the State Association rather than merely being composed of a few of its members.

The social side of the meeting is not generally emphasized sufficiently. The spirit of well-being and goodfellowship will do much to cement the membership to a closer union and will do more good in the long run than a whole program of dry, scientific discussions. Think of the intellectual energy set free around the tables of the old coffee houses in England.

In other words, let the annual meeting be for the education and pleasure of the general practitioner who is the backbone of the Association and an open forum for the free discussion of local problems.

PROPOSED REVISION CONSTITUTION AND BY-LAWS

The Association president, Dr. G. H. Edwards, has appointed a committee consisting of Dr. Frederick J. Waas, Jacksonville, chairman; Dr. W. P. Adamson, Tampa; Dr. F. Clifton Moor, Tallahassee, to make a careful study of our constitution and by-laws with a view to recommending any necessary or desired changes. Any member of the Association wishing to make suggestions is urged to submit his ideas on the subject to the president or any member of the newly appointed committee. All recommendations thus received will have careful consideration by the committee.

Our constitution and by-laws in its entirety

was reproduced in the back of the program at the last annual meeting. If you have misplaced or lost your program, a duplicate will be mailed upon request from the business office, Box 81, Jacksonville. President Edwards has requested the committee to make a preliminary report at the pre-convention meeting which will be held some time in February.

Activities in organized medicine in Florida have been continually gaining momentum and should be governed by a sane and sound constitution and by-laws. We have almost a thousand strong members and, therefore, our constitution and by-laws should be the crystallized ideas of the entire membership and not restricted to the judgment of a limited few. Each member of the Association is, therefore, requested and urged to cooperate with this newly appointed committee in order that the best possible results may be obtained.

CORRESPONDENCE

The Journal is pleased that members of the Association are taking advantage of this column to express their individual views.

The ideas of our members and comments on letters published are solicited.

From Dr. Leland F. Carlton, Tampa, October 3, 1931:

The Florida Medical Association has grown to the extent that, in my opinion, the Scientific Program should be divided into a surgical and medical section. The first meeting could be a joint program of both sections. The following days should be separated into the two divisions, giving double the number of papers and thereby increasing the interest in the different sections.

Another suggestion for the good of the Association is: That scientific papers should start Monday noon and end Wednesday noon. It is quite disconcerting for one to have spent a great deal of time in preparing a paper to have to read it the last afternoon of the meeting and to only the Chairman and a few others who have not yet gone home.

The Railway Surgeons could have their meeting in the forenoon Monday. The regular scientific program starting Monday noon and all papers ended Wednesday noon would insure a little more attention throughout the entire meeting and give the members a chance to be home Wednesday night.

(Signed) LELAND F. CARLTON, M.D.

STATE NEWS ITEMS

Dr. Jack Halton, Sarasota, returned recently from quite an extended trip in the north. Dr. Halton did considerable work at hospitals in New York City, Philadelphia, Washington, D. C., and Richmond, Virginia. He also attended the meeting of the American Proctologic Society and the annual meeting of the American Medical Association in Philadelphia.

* * *

Dr. S. A. Shoemaker of Orlando spent the latter part of June, July and August in the Eye, Ear, Nose and Throat clinics of Chicago. The latter part of that time was devoted to surgery of the nose and the accessory sinuses, including plastic work. He resumed his work in his special line in Orlando September 1st.

* * *

Dr. F. M. Watson was recently appointed to membership on the medical staff of the Florida State Hospital at Chattahoochee.

* * *

Dr. C. W. Pease has been assigned by the State Board of Health as district medical officer for the east coast to succeed Dr. W. A. Claxton who becomes a general health officer at large for the state. Dr. A. C. Hamblin will be in charge of the Tampa district to succeed Dr. Pease who was transferred.

* *

Dr. J. N. Fogarty, Daytona Beach, recently returned from a trip in Nova Scotia.

* * *

Dr. R. B. Harkness, Lake City, visited in Pleasant Ridge, Alabama, during the month of September.

* * *

Dr. W. M. Shaw. Jacksonville, was recently elected president of the Hope Haven hospital staff. Dr. Thomas M. Palmer was elected vice-president and Dr. F. L. Fort, secretary. Other members of the staff are: Dr. T. Z. Cason, Dr. Ralph Greene, Dr. Edward Jelks, Dr. J. L. Kirby-Smith, Dr. W. W. Kirk, Dr. Louie Limbaugh, Dr. Charles B. Mabry, Dr. Kenneth Morris, Dr. A. W. Sears, Dr. J. Knox Simpson and Dr. Clayton Washburn.

* * *

Dr. J. Kent Johnston, Tallahassee, was a visitor in Jacksonville recently.

* * *

Dr. and Mrs. Gilbert Osincup, Orlando, traveled in Canada and New York City during the month of September and Dr. Osincup attended many pediatric clinics on the trip.

Dr. G. H. Edwards gave the annual address September 21st to the graduating class of the nurses' training school of Orange General Hospital, Orlando. The prizes for excellence in the course given by the staff were presented by the staff president, Dr. M. M. Andrews.

* * *

Dr. and Mrs. Alvin Lloyd Stebbins of Punta Gorda announce the birth of a daughter, Sarah Ann, on August 13th.

k * *

Dr. Harold D. Van Schaick, Jacksonville, spent two weeks in the north during the month of September attending clinics.

* * *

Dr. Arthur Walters, Miami Beach, is spending the month of October in New York visiting hospitals and clinics.

* * *

The marriage of Dr. Raymond Keith O'Brien of St. Petersburg to Miss Zita Norpell of Chicago, took place in Chicago June 24, 1931.

* * *

A called meeting of the State Board of Health was held in Tampa recently. Plans were made for operating the Board's activities with the reduced appropriation by cutting salaries and operating expenses. Dr. H. Mason Smith, president, and Dr. Henry Hanson, state health officer, were designated as representatives to attend the convention of the American Public Health Association in Montreal, September 14-17.

* * *

Dr. and Mrs. H. M. Beardall of Orlando spent the month of September at Daytona Beach.

* * *

Dr. and Mrs. Oliver P. Broadbent, Jacksonville, announce the birth of a son on September 11th.

* * *

Before laying down your Journal, please read carefully the editorial on revision of constitution and by-laws and act promptly.

* * *

Dr. Joseph Halton, Sarasota, entertained Dr. W. J. Johnston, president of the Sarasota County Medical Society, and Dr. Stewart Thompson, business manager of the Association, at his beach cottage Monday evening, August 31st. Further plans were formulated in connection with the coming state convention. Dr. Halton is general chairman of the entertaining society.

Reorganization of the staff of Jacksonville Brewster Hospital was recently announced. Dr. W. R. Schnauss has been named supervising medical director to succeed Dr. John F. Boyd.

* * *

Dr. C. W. Boyd, who for the past year and a half has served as intern at the Duval County Hospital, has recently moved to Gainesville where he is to be associated in practice with Dr. G. C. Tillman.

* * *

Dr. Meredith Mallory, Orlando, president Orange County Medical Society, is spending the month of October in and around Chicago attending clinics and football games and visiting members of his family.

* * *

Dr. and Mrs. Douglas Gordon Meighen of Tampa announce the birth of a son, Robert Charles, on August 27th at the Centro Asturiano Hospital.

* * *

Dr. D. T. McEwan, Orlando, is spending the month of October in Cooperstown, New York.

* * *

Dr. and Mrs. Raymond Robert Killinger of Jacksonville announce the birth of a son, William Allen, on August 8th at St. Vincent's Hospital.

* * *

Dr. W. B. Moon of Crystal River was host to the Pasco-Hernando-Citrus County Medical Society Thursday evening, September 10th. A delicious fish dinner was served followed by the scientific meeting held in the town hall. The following resolution was read by Dr. A. C. Hamblin:

"WHEREAS, Statistics indicate that 25 per cent of all deaths from all causes are of children of pre-school age; and

"WHEREAS, Medical examinations of children of school age in Florida show that 80 per cent are burdened by one or more defects that handicap their school work and lessen their earning capacity in later life; and

"WHEREAS, Many of these deaths could be prevented and many of these defects prevented or corrected if brought to the attention of the family physician at the proper time;

"Therefore, be it resolved, by the Pasco-Hernando-Citrus County Medical Society, that a plan and methods be formulated and adopted whereby the members of this Society may cooperate more fully with families and schools for the elimination of such conditions."

The following plan and methods suggested by the committee, composed of Dr. George R. Creekmore, Dr. T. F. Jackson and Dr. George A. Dame, were adopted:

Plan: Publicity in newspapers and by addresses before clubs and other public bodies; contact with parents and the public schools; cooperation with the State Board of Health.

Methods: (A) To furnish articles to newspapers in the three counties; said articles having previously been submitted to the Society for approval. These articles to cover preventable diseases and methods of prevention, correction of defects such as diseased tonsils, defective eyes, adenoids, deformities, etc.

- (B) Instruction of mothers as to proper time for giving immunization against smallpox, diphtheria, typhoid, etc. This instruction should properly begin at the hirth of the child.
- (C) Addresses by members of the Society or by others invited by the Society, hefore Kiwanis, Rotary and other luncheon clubs, Parent-Teacher Associations, school boards, women's clubs, schools, etc., these addresses to cover preventive measures to he adopted by individuals and by those in authority.
- (D) Cooperation with the State Board of Health and other organized agencies in the dissemination of literature and other publicity relative to immunization against preventable diseases.
- (E) Or by other methods which may be found feasible from time to time and adopted by this Society for the prevention of unnecessary deaths, and unnecessary physical handicaps to children of school age and of pre-school age.

In adopting these plans and methods the Pasco-Hernando-Citrus County Medical Society fully realizes the tremendous importance of this work to our community; realizes that with the growth of demand for this type of work and the relative lessening income of the State Board of Health, this work will fall more and more upon our local physicians where it really should fall; and pledges the very best efforts of our members toward cooperation with our public.

* *

Dr. L. W. Cunningham, Jacksonville, attended the Conference on Bone Diseases and Bone Tumors held at Johns Hopkins University, September 14th, 15th and 16th, and also the Thirty-first Annual Meeting of the American Roentgen Ray Society at Atlantic City, September 22-25.

* * *

Omission—Those attending the pre-convention meeting at Dr. Joseph Halton's cottage at Sarasota Beach on August 10th were members of the Executive Committee. No doctors outside of Sarasota were invited except the members of the Executive Committee. The news item in last month's Journal did not explain this.

FOR SALE—Owing to the death of Dr. S. D. Rice, his estate offers for sale all office equipment and library at reasonable price. Wire, write or phone Mrs. S. D. Rice, Gainesville, Florida.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC State Editor Mrs. FDward Jelks,

Mrs. FDWARD JELKS, 2244 St. Johns Avenue Jacksonville

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Mrs. J. M. Irwin, Historian St. lugustine

We are late in publishing these excerpts from Mrs. James F. Percy's "Panoramic View of the Western District," owing to lack of space until this time. We felt that the message of our National President, our own State news and messages from our State Chairmen and County Auxiliaries, should be given preference. What Mrs. Percy has to report of California is especially interesting—their chart, "The Technique of Following a Bill Through the Legislature." Of course, Florida hesitates to copy California, but we are forced to admit that such a chart would be most enlightening to our State Auxiliary.

PANORAMIC VIEW OF THE WOMAN'S AUXILIARY TO THE A. M. A. IN FOUR ARTICLES.

4. WESTERN DISTRICT Mrs. James F. Percy

As my division in the organization work covers the states of the far West, branching to the middle states only to include Nebraska, this panorama will begin there. We have been enjoined for so many years to "Go West", it has now become a favorite direction of travel.

Nebraska is always up and doing and a survey of activities of 1931, shows an extensive distribution of the National Auxiliary Study Envelope on "Communicable Disease Control"; much wel-(Continued on page 192)

William D. Jones

Pharmacist

Laura and Adams Streets Jacksonville, Florida



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fare work, especially providing professional visiting nurses for public schools in various counties and definite organization of county relief work at a great saving to the county commissioners. Here indeed is a far-reaching benefit for the community at large in a practical, economic way. Benefits are held to procure funds for completing files of scientific books and magazines and research work of the pathological laboratory connected with the Sharp Building Library at Lincoln. The Auxiliaries' scientific educational programs contain many important names, these together with social and philanthropic activities keep everyone interested, useful and happy. One new county auxiliary has been reported as a last gift to this admin-

Colorado has kept up the interest aroused during the national presidency of Mrs. F. P. Gengenbach of Denver, particularly with spreading ideas of good and better health through the use of literature in the less populated districts. Included with this, study envelopes have been used and a greater field developed for approved health programs in other organizations. Growth in numbers has not been sought so much as growth in achievements.

New Mexico, with but one county, Bernalillo, organized and far from all centers of activity, has been an inspiration by their efforts to follow the national precepts. Unless one has traveled the great spaces of the deserts of the southwest, no conception of its distances can be formed. This one county has taken up Child Welfare work, sale of tuberculosis seals, enjoyed programs from their medical men, county charities chairman, county health nurses and state director of public health and carried the social activities of the State Medical Convention. They are few in numbers, but verily the leaven quickeneth the whole loaf.

Arizona has trebled its units from one to three but has found organization work difficult due to distances. Social features have prevailed unless some definite need has loomed in the offing, such as the Basic Science Bill, for the passage of which the State Auxiliary made great effort. In a state so filled with cults the passing of the Bill by the senate was a real achievement, even though it was finally held up in committee. However, nothing daunted, the members are now aroused to the possibilities and usefulness of an auxiliary and experienced women are stepping forward, willing to serve and assist in making an active, worthwhile organization.

(Continued on page 194)



See Description, Journal A. M. A. Volume XLVII, Page 1488

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California has been concerned, aside from organization, with establishing itself upon a permanent foundation through a proper Constitution and has been able to do this with the full support of the California Medical Association, which is printing these Constitutions as a gift to the State Auxiliaries.

At the recent State meeting, held in San Francisco, April 27-30, 165 women registered, with 55 delegates and 115 women seated at the annual luncheon. The Auxiliary now feels safely established and on its keel.

The keynote of each county report was education but the social side, welfare work, Red Cross, changing the position of a State senator, creating sentiment for a tuberculosis sanatorium, local philanthropies, all had their places with the scientific programs. A chart, "The Technique of Following a Bill Through the Legislature", provided a most unique, striking and valuable object lesson of information as to what we are all up against in our legislatures and their procedure. This subject is highly recommended to all organizations.

The interest shown and the friendliness in the social life at this convention demonstrated a new order which we hope has come to stay.

Oregon has chiefly concentrated upon organization work and revival of general interest this year, through providing the units with a list of suggested study topics to encourage a similarity of subjects.

To those who were fortunate enough to attend the national meeting at Philadelphia, no further stimulus will be needed.

ADVERTISERS' NOTES

Some time ago, the R. B. Davis Company of Hoboken, New Jersey, cooperated with health authorities in Arkansas in an unusual test. Cocomalt clinics were established in the drought area and the children placed under the care of an attending physician and registered nurse. The children were given Cocomalt mixed with milk once a day. The average gain for forty days was 8½ pounds per child. One of the most outstanding features of this work was that in thirty children that were checked an increase in hemoglobin from 5 to 15 per cent was indicated.

The splendid results obtained with Cocomalt in Arkansas with only one feeding a day are further evidence of the high nutritive quality of this delicious food drink. Though it provides all the (Continued on page 196)



M EDICINE in its every phase will be covered in the general and clinical sessions, the sixteen sections and the three conjoint meetings—the American Society of Tropical Medicine, the National Malaria Committee and the Southern Association of Anesthetists—making up the program for the New Orleans meeting—the LAST WORD in scientific and practical medicine and surgery. A medical meeting complete in every respect—at New Orleans, the great medical center and the city of romantic traditions, Wednesday, Thursday and Friday, November 18, 19 and 20.

AT THE SOUTHERN MEDICAL ASSOCIA-TION meeting one gets the most complete and best rounded out program and program arrangement and just enough entertainment, social and recreational activities, to make a medical meeting complete. The Southern Medical Association meeting has an atmosphere known to no other medical meeting the atmosphere of the new South tempered with the cordiality and charm of the old South.

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Of interest to all medical men is a recent news item from Indianapolis announcing plans for the construction of a new medical research laboratory by Eli Lilly and Company. Ground was broken about October first. Originally it had been planned to start construction next spring. On account of the labor situation it was decided to advance the work which will give employment to a large number of men throughout the winter months.

For some years Eli Lilly and Company have placed special emphasis on medical research. Eighteen years ago a fine new building was erected to house the staff and equipment of a scientific department. As opportunities presented themselves the work of this division of the business has expanded until the facilities were no longer adequate to the needs of the company.

Eli Lilly and Company are authority for the statement that this new research unit will be the finest of its kind in the county. It will be four stories above ground. The dimensions will be 222x50 feet with an auxiliary building at the rear 84x50 feet. The structure will be of monumental design, of reinforced concrete with brick exterior.

The building will house the latest and most advanced scientific equipment. It is said, on good authority, that the value of the interior furnishings and laboratory apparatus will greatly exceed the cost of the building. Another feature of this new Lilly medical research unit will be a very complete scientific library which will occupy the top floor of the building. It is interesting to note that in addition to the present science building the company also maintains research laboratories at its biological plant outside of Indianapolis and also at the Marine Biological Laboratories, at Woods Hole, Massachusetts, during the summer months. (Continued on page 200)



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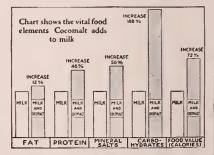
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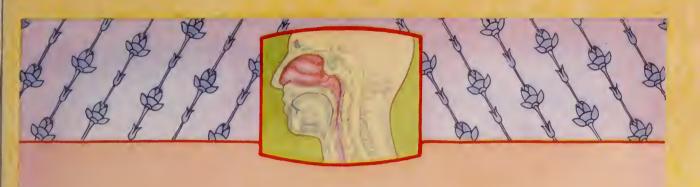


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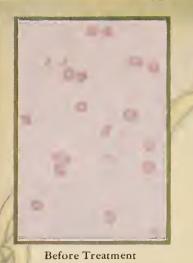
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shows 85-86% protein content. Knox is therefore usually preferred to ready-prepared gelatine desserts which actually contain only about 12% gelatine. Pure granulated gelatine is regarded as readily digestible and quickly absorbed.

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WESTVILLE CREAM

(Six Servings)

	Grams	Prot.	Fat	сно.	Cal.
11/2 tablespoonfuls Knox Sparkling					
Gelatine		9			
1/4 cup cold water					
1 square chocolate, grated		4	15	9	
3/4 cup hot water 3/4 cup milk					
3/4 cup milk	180	5	7	9	
2 eggs		13	10.5		
14 cup cream, whipped		2	18	2	
5 tablespoonfuls sugar				40	
I teaspoonful vanilla					
Few grains salt					

Total 33 50.5 60 826.5

Soak gelatine in cold water. Heat chocolate, water, milk and salt over hot water, then add gelatine and stir until dissolved. Separate eggs and beat egg yolks until lemon colored. Stir hot mixture slowly into egg yolks. Return to stove and heat over hot water until mixture thickens slightly. Remove from stove, add vanilla and chill until nearly set. Beat egg whites until stiff, fold into jelly, also whipped cream. Mold and chill until firm.

LEMON MIST

(Six Servings)

	Grams	Prot	. Fat	CHO	Cal.
1 tablespoonful Knox Sparkling Gelatine	. 7	6		٠.	
1/4 cup cold water					
11/2 cups hot water					
Grated rind 1 lemon					
1/4 cup lemon juice	40			4	
2 eggs	. 100	13	10.5		
2 table spoonfuls sugar	. 16			16	
,	Total	19	10.5	20	250.5

Soak gelatine in cold water, Boil rind of lemon in water used for dissolving gelatine; add sugar; pour on soaked gelatine—stir until dissolved. Pour this into well beaten egg yolks. Return to stove and cook over hot water until mixture thickens slightly, stirring constantly—add lemon juice and pinch of salt. When nearly set fold into egg whites which have been beaten stiff. Mold and chill.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY	AD CODE A DUI	MEETINGS I				Dues
SOCIETY	SECRETARY	Date	Time	Place	Luncheon?	Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	-11d Tuesday	12:00 Noon	White House	Yes.	77%
Вау	D. M. Adams, M.D., Panama City.					100%
Brevard	1. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		80%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	chamber of Coin- merce	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		86%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally	81%
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	100%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	84%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	84%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillshoro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	82%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	83%
Madison	Geo. O. Davis, M.D., Madison.					68%
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.		Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	68%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Court House	Yes.	90%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thursday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	98%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies .	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
Washington- Holmes						25%
	NOTE-Secretaries: P	lease submit inform	ation to some	alete the above ashe	dula	



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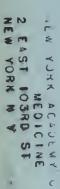
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THE JOURNAL

Florida Medical Association, Inc.

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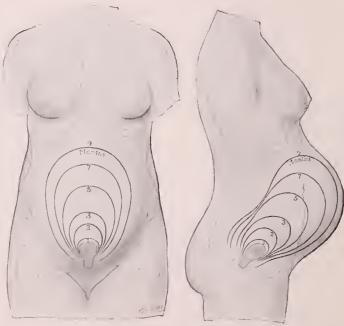
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

Volume XVIII

Jacksonville, Florida, November, 1931

Number 5

THE PRESENT STATUS OF THE INJEC-TION TREATMENT OF INTERNAL **HEMORRHOIDS***

LEIGH F. ROBINSON, M.D., F.A.C.S., Fort Lauderdale.

According to Anderson, the injection treatment of internal hemorrhoids did not originate in America, as is generally recorded, but was first employed by a Mr. Morgan of Dublin in 1869. He used an iron perchloride solution, a method that had been used in the treatment of nevi. In 1871 carbolic acid was first used as an injecting agent by a quack named Mitchell at Clinton, Illinois. Mitchell kept his formula a secret, but sold it to a number of non-medical "pile curers." Because of the type of man which employed the method, whatever good results might have been obtained were overshadowed by the notably poor ones, and the medical profession naturally was very strongly against it. So extensive was its use that Professor E. Andrews of Chicago as early as 1876 was able to collect the results in 3,300 cases. From one of the quacks to whom Mitchell sold his secret, Professor Andrews obtained the formula. He learned that Mitchell used one part carbolic acid to two parts of olive oil. The secret having been laid bare by Andrews, a great many medical men, ethical and otherwise, gave the method a trial. It took, however, a generation of time for the prejudice brought about by the traveling "pile-curer" to disappear to a point where ethical men felt free to lend their endorsement.

Dr. Carter F. Martin, a prominent proctologist of Philadelphia, began its use in 1899. Four years later he read a paper on the subject before the American Proctologic Society. He used a proprietary phenol solution, and limited its use to internal hemorrhoids. Practically all the solutions for the next fifteen years contained phenol in some strength.

In 1914 E. H. Terrell of Richmond began emploving a five per cent solution of quinine and urea hydrochloride. He had noted while using a two per cent solution of quinine and urea hydro-

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931. chloride as a local anesthetic into the skin or cellular tissue that a marked fibrous edema was produced which lasted several days. Therefore, when using the drug as a local anesthetic in anorectal operations and observing this reaction, it occurred to him to utilize this agent in the same manner as phenol had been employed in the treatment of internal hemorrhoids. He found, however, that stronger solutions were necessary to get the effect in a vascular tumor. In 1916 upon reporting his first series of cases he recommended quinine and urea hydrochloride as a substitute for phenol. His results in this series were quite remarkable as the hemorrhoids had disappeared under this treatment, without any of the complications such as sloughing and hemorrhage, that had been so common heretofore with the phenol method. The agent in addition had a peculiar and lasting anesthetic effect, which rendered it ideal for the purpose.

Since Terrell's introduction of quinine and urea hydrochloride the injection method of treating internal hemorrhoids has rapidly gained in favor in this country. However, at the time he reported his first series of cases before the American Proctologic Society he was severely criticised by many members of that distinguished organization, most of whom have since changed their position and employ the method to some degree.

Other leading proctologists in America endorse the method highly. However, without exception its use is limited to uncomplicated internal hemor-Jerome Lynch states that while the method is not popular because it has been exploited by quacks, it has been taken up seriously by the regular profession and very good results have been obtained in the hands of careful men. Charles D. Aaron's experience with the injection treatment has been satisfactory in a large number of cases; his objection to the method is that it requires a much longer time than does surgery. Hill's experience with quinine and urea hydrochloride has been most gratifying. He feels that the method is certainly to be preferred whenever operation is out of the question. He uses the method but prefers operation unless refused or contraindicated. Goldbacher says that he has never seen a case of internal hemorrhoids treated

properly by the injection method yield untoward results. Buie approves the method, that is, if there is a selection of cases and the method is properly carried out. Pruitt has written freely on the subject, and is quite positive in his statement that the injection method is preferable to operation in properly selected cases. Hirshman has used the method many years in private practice, and has found it satisfactory. He uses quinine and urea hydrochloride, but he believes it is much more rational to remove the hemorrhoids by a clean cut surgical operation under local anesthesia.

In England the treatment has had a wider use probably than in this country. However, there phenol in strengths varying between five per cent and twenty per cent has been used as the principal injecting agent. According to Morley, the treatment was introduced into England in 1888 by Swinford Edwards. Morley probably did more than any surgeon in his country to clear away the opposition to the method. During the war he began to employ the method at St. Mark's hospital to soldiers and war workers. He found that because of a crowded condition of the hospital wards, that many cases of piles had to wait months before they could be admitted for operation. They would come to the out-patients' ward because of bleeding and pain and not infrequently were disabled from work because of their hemorrhoids. His attention having been called to the injection treatment, he decided to try it more as a palliative measure, but he was surprised to find that when these men returned to the hospital for operation, their hemorrhoids had disappeared and operation therefore was unnecessary. He gradually came to treat a very large number of cases of internal hemorrhoids by means of injection, and only recommended for admission and operation cases where there were complications such as fissure, fistulae, etc. In his publication on hemorrhoids, he states that after years of experience with the method he is convinced that the cases in which treatment by injection is contraindicated are quite exceptional, and that recurrence is no more common after injection than after operation. He has used the method in thousands of cases, but believes that it requires special instruments and skill and experience; he does not think it should be attempted by those who have only a few opportunities for its employment, but strongly recommends it to rectal surgeons. Another English surgeon, Dr. James Eadie, stated in 1921 that he would relegate to operation only those few cases in which for some reason the speculum can not be introduced without a general anesthetic, or when an anesthetic has to be given for some intercurrent condition. Mummery feels that it is not as good a method as operation and should not be used unless there is special contraindication to operation. He believes, however, if the treatment is carefully carried out, that there is little, if any, danger in it.

The more recent literature, that is since 1925, shows undoubtedly the rapid growth in favor of the method. Terrell in May, 1925, stated in a paper before the American Proctologic Society that the former prejudice against the injection treatment was being dispelled, as men of undoubted character and professional standing are announcing their satisfaction from its use. He warned, however, that there are many possibilities for error in injecting hemorrhoids and that the inexperienced operator will hardly carry out the treatment to completion without trouble of some kind.

Rolfe in an article, March, 1928, after observing results at the Boston dispensary, believes that while the method has its limitations in uncomplicated internal hemorrhoids, it gave them satisfactory results in a high percentage of cases.

ADVANTAGES OVER OPERATION

Fansler, in reporting 2500 cases, sums up the advantages over operation by stating that there is no loss of time from work; the injection is less painful and disagreeable than operation; many patients will submit to this form of treatment when they refuse point blank to be operated upon, and, therefore, it serves as a means for relieving their sufferings; it may be used in a large number of patients whose physical conditions would contraindicate operation.

COMPLICATIONS

Morley in over 3,000 cases tabulated complications of every character as follows:

- (1) Severe pain in ½ of 1%.
- (2) Secondary hemorrhage in 1/4 of 1%.
- (3) Minor sloughing in 2.0%.
- (4) Perineal abscess, 1 case.
- (5) Irritable bladder, 1.0%.

He states that he has never heard of any trouble from the oil finding its way into the circulation, nor has he ever had any trouble from hemorrhage at the time of the injection.

A. E. Chase of New York, discussing a paper by Terrell, in a plea for the operative method of hemorrhoids, said that he had only seen two deaths in several hundreds of operations. The first was due to a gas bacillus infection along the peritoneum and scrotum after a so-called sterile water anesthesia in the clinic. The second death occurred in a man where quinine and urea hydrochloride anesthesia had been used.

Buie has encountered a number of cases of sloughing coming to the Mayo Clinic, that had been injected elsewhere. A slough, however, denotes faulty technic, and most men who use the injection treatment admit that those cases of sloughing they have had in their own practice have been in their early cases, before their technic was developed.

RECURRENCES

Terrell believes if proper selection of cases is made and if the technic is faultless, that cures approximating 100% will be obtained.

Compared with operation, Pennington estimated that ten per cent of the patients referred to him for operation have been operated on two or three times. Martin, in 4200 cases treated by injection method, had about fifteen per cent recurrences in three to five years. Crivelli of Melbourne, in 1929, in recommending the injection treatment, stated that the only drawback is the possibility of recurrence, but that this also happens after operation. However, the injection method is so simple that the patients are well content to submit to other injections, when they will rarely submit to another operation. At the Boston Dispensary, Rolfe reported in 1925 recurrences in a small number of cases, usually one to three years after treatment, but they were due almost invariably to an insufficient number of injections. They employed five per cent quinine and urea hydrochloride and saw no complications of abscess formation, sloughing, or hemorrhage.

POINT OF PREFERENCE FOR INJECTING SOLUTION

Difference of opinions as to how piles should be injected is noteworthy. Most surgeons using phenol solutions usually inject into the submucosa and not into the pile mass. Where quinine and urea hydrochloride is employed, deeper injections are the rule. Personally I favor a five per cent solution of quinine and urea hydrochloride and inject into the submucosa at the base of the pile mass into what someone has called the stalk of the varicose loop.

PATHOLOGICAL REACTION

Duke studied the tissue changes caused by phenol injections. In ten subjects, one pile tumor was injected as usual, and this injected mass with a control not treated, was later excised, the interval between injection and incision ranging from one to twenty-one days. He decided that phenol, being a powerful irritant, initiates an aseptic inflammation, characterized by dilatation of vessels, emigration of leucocytes, and transudation of lymph. By these means, the alien fluid is diluted and removed; thereafter the inflammation quickly subsides. All the changes observed microscopically represent the effort of the tissues to repair an injury. The inflammatory changes in the first three days do not play any important part in the cure of hemorrhoids; it is the secondary changes, in particular the intra-vascular clotting and subsequent fibrosis, to which any beneficial effect must be ascribed. Pruitt points out in discussing Duke's conclusions, that he believes that the early inflammatory changes that occur in the first three or four days account for the secondary change or subsequent fibroses, and gives the principal credit to the early inflammatory changes for the cure of the hemorrhoid.

Morley, who uses phenol, states that his observations indicate that oil remains unabsorbed for a considerable time and sets up an aseptic inflammatory reaction between the mucous and muscular coats of the rectum with subsequent formation of dense scar tissue which binds these coats closely together. The oil while still standing in position and distending the mucous membrane keeps up a continuous pressure on the vessels of the pile mass, and the scar tissue which forms at a later stage must tend by its contraction to obliterate any vessels which have escaped the effects of the pressure of the oil.

GENERAL COMMENT

Since it is generally agreed that internal hemorrhoids without complications constitute the only type suitable for the injection treatment, it is absolutely essential to have a sufficient knowledge of the anatomy of the rectum, not alone to know how and where to inject, but that the operator will be able to properly select the hemorrhoids suitable for treatment. Internal hemorrhoids should be easily recognized because they are always covered by mucous membrane and are innervated only by sympathetic fibers. The spinal nerve supply is distributed to the anal skin and tissues below the anorectal line. Therefore, the injections are made only in a practically painless area. It has already been brought out that the injections should never be made in the presence of rectal ulcer, fistulae, strangulated unreducible hemorrhoids, or in any active inflammation or new growth. Terrell, in summing up one of his early papers on the subject, stated that the injection treatment of hemorrhoids appears simple, but a thorough knowledge of rectal diseases is essential if one expects uniformly good results. Most important of all is the realization of the class to which it is suited and its limitations.

In preparing this paper there has been no effort to bring out the advantages of one drug over another or to endorse any particular technic. Because prejudice against the injection treatment has existed so long and in some quarters continues to exist, it was believed well to review the opinion of today of leading proctologists regarding this method of treatment. There can remain no doubt that the proctologists of this country and England have accepted the injection treatment as having an undoubted place in rectal therapy and that they believe the theory of its use is sound in principle and works out in practice. Therefore, a wider knowledge of its principles and indications should result in a more general adoption of the method. Surgery, however, will continue to be the ideal treatment in a large percentage of cases.

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DISCUSSION

Dr. Jack Halton, Sarasota:

I could take five months instead of five minutes as allowed by this Association and still be discussing the injection treatment of hemorrhoids. It was my pleasure and honor to be associated with Dr. Terrell, of Richmond, Va., from the inception of the idea of using quinine and urea for this work.

Long before that time I had worked with Dr. Collier F. Martin of Philadelphia, who with his father, had been using the injection method for years, with success, in thousands of selected cases, that refused operation. He was using a preparation (French) called Phenol Bo-Boufe.

The injection method appealed to me for the simple reason that by the use of these solutions, accompanied by a proper technique one could take a poor man, who did not have time to go to a hospital and who had no money to pay for an operation, put him on the table, give him a treatment and get him back to work in five or six minutes. By following up this method, repeating the injections every four or five days for a period of four to six weeks, the patient could be discharged perfectly well.

I will not go into the action of quinine and urea for Dr. Robinson's paper fully explains that. Quinine and urea used in a five per cent solution is sure to clear up the trouble.

Yes, some men do manage to get sloughing in the treatment of hemorrhoids by the injection method, but bear in mind this condition only ensues where an improper technique is followed. Sloughing occurs only where the fluid is shot through the hemorrhoidal vein and into the rectal muscle or into the true skin below the pectineal line (Hilton's White Line). Gentlemen, if you do this you will get into trouble every time. Put the fluid into the vein. For, as you withdraw vour needle, should vou notice very much blood escaping, you have gone into the wrong spot and will not get the results you are looking for. Your puncture has been made too deep and in the wrong direction. That is why there are so many failures in this class of work.

The method of Dr. Terrell is to inject not at

the base of the pile, but high up and well into the pile itself. In this way he gets his best results, and no sloughs. I have been following this method of work since 1914 and have had no sloughing except in my first few cases where I made the injection too low or into the muscular tissue, but I was not long in perfecting my technique thereby making it impossible for sloughing to occur.

As I said before, you will get slough if your technique is faulty. I have been using quinine urea from 1914 up to about two years ago, when I tried some experimentation with the phenol and oil solution of which I will speak later. As Dr. Robinson states in his paper, the injection treatment of hemorrhoids has had, and still has, a hard and rocky road to travel. We men who took it up in the early days had a fight on our hands. We could not mention the use of the injection method without bringing down upon our heads a storm of protest from men who had never tried the method, men who were merely prejudiced against it, or men who had, through faulty technique, or carelessness, and poorly prepared solutions, failed to succeed.

I was on the floor of the American Proctologic Society when Dr. Terrell first advanced his idea of the use of quinine and urea for the cure of hemorrhoids. Dr. Rawson Pennington of Chicago, a great proctologist and one of the leaders in our line of work, stated that he was surprised that any Fellow of the American Proctologic Society would have the assurance to advocate or advance the idea of the cure of hemorrhoids by injection; that there was only one way to get rid of hemorrhoids and that way was by surgical methods; that the injection method was an emanation from the brains of quacks, charlatans, and commercial so-called "pile curers," and that he considered that to advance the idea was taking a step backwards in progressive proctology.

The following year Dr. Pennington admitted at the annual meeting of the American Proctologic Society, that he had been wrong and that he was then using quinine and urea in some selected cases that refused surgical procedure.

For the past three years I have been combining the use of quinine and urea with a five per cent solution of phenol and oil and with this combination, I have found no need for the selection of cases, as all types of internal hemorrhoids are amenable to this method of treatment. Of course, strangulated cases require pre-injection care and treatment. Such pathology as anal fissure, skin tags, tight sphincters, infected crypts, should be treated and surgically removed.

If phenol is used, inject into the mucosa and not into the pile mass. When you get a striated appearance of the hemorrhoidal tissue slowly withdraw the needle and if no blood follows, you have made a successful injection and are bound to get results. Don't inject only one cc. of the solution, but go wherever you find any loose tissue in the rectal pouch. Go up two inches or more and inject all the loose tissue you find. A five per cent solution of phenol in oil, properly compounded, will do the work.

I should like to go over my experience and give case reports in the treatment of anal prolapse by this method. I first used it only in selected cases but experience has taught me that it can be used successfully in all forms of internal hemorrhoids and anal prolapse.

Dr. J. W. Snyder, Miami:

I wish to commend Dr. Robinson for his very conservative evaluation of the injection method for the treatment of hemorrhoids.

Surgical removal of hemorrhoidal varicosities may be employed in any type of case, but, as has been stated, the injection method is only suitable to certain types of internal hemorrhoids and not at all to the external pile. The internal hemorrhoid should not be markedly prolapsed or thrombosed or infected or ulcerated. It should be of moderate size and there should be no other complicating rectal pathology. If the internal pile is treated and an external pile left, recurrence of the internal varicosities is very certain. We must, however, recognize the patient's viewpoint and if relief is possible without surgery, he should be given the benefit of such measures as will secure palliation at least and in many cases produce a permanent cure.

I believe the injection method requires much more skill and judgment than surgical removal of hemorrhoids. In expert hands excellent results can be obtained but the dire results often seen with sloughing of tissue, gangrene of the rectum, abscess, rectal prolapse and stricture formation, all tend to emphasize the fact that expert knowledge and experience are highly desirable.

I wish lastly to congratulate Dr. Robinson on his attainment of this very necessary ability. Dr. L. F. Robinson, Ft. Landerdale (concluding):

I want to express my appreciation of the liberal discussions of Drs. Halton and Snyder. I am firmly convinced that the injection treatment of internal hemorrhoids is preferable to operation in

a large number of cases and that the indications for this type of treatment will sooner or later be extended to cover the treatment of almost 100% of internal hemorrhoids. But let me sound a warning. Given a case of hemorrhoids it is far better to have the case operated upon by a surgeon of little experience than injected by an inexperienced practitioner. In other words, I believe the injection treatment in the proper hands is one of the greatest advances in the treatment of hemorrhoids, but in the wrong hands is a dangerous method.

NEWER KNOWLEDGE OF NUTRITION*

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Prior to the beginning of the present century the opinion seemed to prevail that the physiology of nutrition had reached a point beyond which there was little possibility of progress. The subject was thought to have been thoroughly investigated and as a result it was regarded as offering little opportunity for further study for some time at least. Absurd as it may seem, this unique attitude exists at the present time concerning certain phases of nutrition.

At the beginning of the present century, the existing knowledge of nutrition was based almost entirely on the chemistry of living tissues. The analyses which had been made established that the body of an animal or the tissues of a plant were, in the main, composed of proteins, carbohydrates, fats and a large amount of water in addition to a number of inorganic elements in different forms. The fats were studied chemically and much was learned concerning their conversion into fatty acids and their saponification in the process of digestion; the carbohydrates were examined and their inversion into simpler sugars was also learned by chemistry. The proteins, however, were soon found to be more complex in structure and the progress made with them was not so rapid or satisfactory. In any event, the consistent presence of these substances in the tissues of animals and plants established them as fundamental factors in the diet of animals and the proportions in which they should be present in food became the subject of deep study and wide discussion by students of nutrition. Moreover, they formed the foundation of the study of the entire subject.

^{*}Read before the Duval County Medical Society, Jack-sonville, October 2, 1931.

Various articles ordinarily used by man as food were diligently analyzed as sources of these nutritional elements and a vast amount of information was accumulated. Long lists of food-stuffs were compiled and classified by Voit, Atwater and the famous Liebig, but it seems that none of these investigators ventured beyond chemistry in their efforts to determine the value of these articles of food.

As long as the study was confined to the utilization of chemistry to elicit information, the progress was necessarily limited and modern students of nutrition regard it as remarkable that the chemical results were not checked by feeding experiments on animals, especially when evidence existed in the literature of the day that a diet which was chemically correct was often unsatisfactory for the nutrition of man.

When it was realized that chemistry had distinct limitations in the problem of nutrition, investigators turned to animal experimentation for the purpose of acquiring further knowledge. It had been realized for hundreds of years that certain diets of stale food caused scurvy among sailors, soldiers and prisoners. Moreover it was also known that fresh vegetables and fruits would promptly cure scurvy. As a result vessels embarking on long voyages were required to include an adequate supply of lime juice in their stores before leaving. It is said that this requirement still remains in the regulations of the British Board of Trade and is the origin of the sobriquet, Limey, which was applied in a jovial spirit to the British soldiers by their comrades in the allied armies during the recent war. Nevertheless, no concerted effort was made to determine the cause of this disease or ascertain why the therapy was so effective until the second decade of the present century.

Beri-beri had also been known to exist for many years and the Japanese demonstrated beyond doubt that it was due to dietary deficiency by noting the incidence of the disease aboard a ship that embarked on an eight months' cruise under Admiral Takaki as compared to another ship which was sent on a similar cruise over the same course with an improved diet furnished to the men.

Again it was many years after before a solution of this problem was approached. It was in 1897 that Professor C. Eijkman, of the Department of Hygiene of the University of Utrecht, undertook to determine whether or not the diet of

polished rice, so universally used in the Orient, was the specific cause of beri-beri. He fed pigeons and chickens on a diet of polished rice and in a few weeks produced a type of paralysis that, in almost every way, simulated beri-beri in man, and thus earned the credit of being the first investigator to produce a dietary deficiency disease experimentally.

As a result of his studies the first knowledge that the rice bran, which was removed in the process of polishing, contained a protective substance was revealed and this led to the introduction of the term vitamin.

Funk, who confirmed the experiments, suggested the name for this important essential element.

As a result then of these animal experiments our first real worthwhile information was acquired concerning the accessory food factors now recognized as being so important in the prevention and treatment of diseases of nutrition. The study had reached a point where we were about to acquire information concerning factors which were known to exist, but which were imperfectly understood. From that time on the popularity of the study knew no bounds and the observations of the earlier investigators opened up a field of research which is now replete with many spectacular achievements. On the other hand, unscrupulous purveyors of foods have grasped the opportunity to take advantage of a public which is extraordinarily gullible if one is to judge from the present day trend of advertising. Much misinformation has been disseminated concerning the mysterious substances spoken of as vitamins, and it seems desirable to discuss some of the more legitimate advances which have been made concerning these factors. At the present time, studies which have been made of the accessory food factors essential to normal nutrition and to the prevention of various deficiency diseases have revealed the existence of six independent vitamins. The first of these is the vitamin A.

Vitamin A. This vitamin is fat-soluble and is frequently referred to as the antixerophthalmic, antiophthalmic or anti-infective vitamin. Experimental and clinical investigation have revealed the fact that it is essential for growth, resistance to infection, and is a potent factor in reproduction. Animals or children who are deprived of this substance over any great period may develop a characteristic softening, cloudiness and finally necrosis of the cornea which is spoken of as xerophthalmia and keratomalacia

This condition is said to be analogous to "night considered necessary for sustaining normal blindness" which is observed among Eskimos and certain Japanese coolies and can be cured by the administration of cod liver oil which is rich in vitamin A.

This condition is said to be analogous to "night considered necessary for sustaining normal growth, it seems possible that the apparent inactivity of carotin in earlier work might well have been due to the absence from the test diets of adequate supplies of vitamin D. Upon testin

This vitamin also is a most important factor in the prevention of infections of the respiratory system. It increases resistance to sinusitis, coryza and other upper respiratory infections. It is also believed to prevent infection of the intestinal mucous membrane. It is associated with the vitamin D in the prevention of osteomalacia, osteoporosis and rickets. Deprivation of vitamin A has caused degeneration of some nerve bundles.

The generally accepted sources of vitamin A at the present time are milk, eggs, liver, cod liver oil and the green and yellow pigmented vegetables. As a general rule cod liver oil is most frequently used as a source of this vitamin in the diet of young children. Numerous studies have been devoted to this particular vitamin and some of the more recent reports seem to indicate that we are on the threshold of obtaining valuable information concerning it.

Ten years ago Rosenheim and Drummond⁴ published an important communication in which the possible relationship of vitamin A to the carotinoid pigments was discussed. While pointing out that the vitamin could not be identified with any familiar carotinoid, they suggested that some unknown pigment might be involved, or that the vitamin might be formed from a carotinoid by the action of light, as was later proved with ergosterol. Although considerable evidence existed to show an association between carotin and the vitamin A in their natural sources, the work of Drummond and Coward⁵ and of Stephenson⁶ showed that crystalline carotin, if carefully purified, was ineffective when supplied to rats as the sole source of fat-soluble vitamins. Interest in the problem was again reawakened by a reference of Drummond, Channon and Coward⁷ to the pigmented nature of cod liver oil concentrates, but eventually the identification of ergosterol as being the source of vitamin D gave rise to the speculation that this sterol, rather than a carotinoid, might also be the parent of vitamin A.

As a result of a contribution by Euler, Euler and Hellstrom,⁸ fresh evidence as to the vitamin A activity of the carotinoids has been made available. It is pointed out that the earlier work on this subject took place before the separate existence of vitamin D and A was realized. Since both these vitamins as well as the B factor are now

considered necessary for sustaining normal growth, it seems possible that the apparent inactivity of carotin in earlier work might well have been due to the absence from the test diets of adequate supplies of vitamin D. Upon testing crystalline carotin as a source of vitamin A in conjunction with a basal diet adequate in vitamin D, the Swedish workers have observed resum; tion in the growth of rats on dosages as low as 0.005 mg. per rat per day.

Apart from such direct biologic evidence, chemical similarities between the carotinoids and the vitamin can be traced. Both the pigments and the vitamin resist saponification and are destroyed by oxidation or exposure to ultraviolet irradiation. On treatment with the antimony trichloride reagent, moreover, somewhat similar blue colorations are produced. Euler and his coworkers, realizing the importance of this side of the problem, have made these colorations the subject of a detailed spectroscopic examination.

It is well known that the carotinoids give to butter its characteristic color. Thus far no function had been definitely ascribed to carotinoids, although they were known to produce a yellowish discoloration of the body designated as carotinomia.

In view of the possible relationship, in butter fat, of color to the protective action against a pellagra-like syndrome in dogs, experiments were carried on by Underhill and Mendel with both egg yolk and carrots as a substitute for butter fat. The results have demonstrated that cgg yolk conveys a certain degree of protection but is not as effective in alleviating the syndrome when it is once initiated. So impressed were these investigators with the efficacy of carrots as a curative agent, that they adopted as a working hypothesis the possibility that the effective agent is either this natural pigmentary substance or some unidentified compound associated with it.

Moore⁹ recently experimented with two samples of carotin supplied him by Dr. von Euler and Dr. R. A. Morton, of Liverpool University, and supported the claim that this substance may prove active as a source of vitamin A. He showed that it is effective in sustaining a good growth in rats when supplied in the minute dosage of 0.01 mg. daily.

Thus the study of the relation of carotin to the vitamin A continues and adds to the interest in this first food factor as well as the studies which have shown that it is so important in the prevention of infection.

Vitamin B. In contrast to vitamin A, this vitamin is never associated with fats or oils of either animal or vegetable origin, and while it has long been known to be the cause of polyneuritis in man and in experimental animals, it has only been recently that interest was awakened in this vitamin. It has been shown that it has a dual nature, so that it has become necessary to designate one portion of it as the vitamin Bi or P and another B2 or G. Therefore the original vitamin B may now be spoken of as possessing characteristics of two distinct vitamins. Recent studies in pediatrics have indicated that foods which were deficient in vitamin B1 are often responsible for troublesome anorexia in infancy and early childhood. When an adequate amount of vitamin Br is introduced into the food, the loss of appetite is frequently overcome and the growth and development of the child improves at once. Hoobler's10 studies in this connection have been so convincing that many pediatrists are beginning to believe that unless we provide an adequate amount of vitamin B with the carbohydrate which we add to the infant's formula, we are not giving our patients the benefit of our newer knowledge of nutrition. Hoobler found that when certain patients had anorexia, loss of weight, spasticity of the arms and legs, rigidity of the neck, restlessness, pallor and a low hemoglobin, that they were suffering from a vitamin B deficiency. All of these conditions cleared up promptly when vitamin B was added to the diet. Our interest therefore in this particular vitamin has now gone considerably beyond the knowledge that it is capable of producing beri-beri in adults and in young children.

The chief source of vitamin B₁ is the wheat and corn germ, yeast and the polishings removed from rice. It also occurs to a smaller extent in vegetables, milk, lean meat and liver.

The vitamin B₂ or G as it is sometimes spoken of in honor of the late Joseph Goldberger, is the anti-pellagric vitamin. In rats, its absence results in lesions, similar to those occurring in human pellagra.

It is believed by many that pellagra is due solely to its absence in the diet. In any event, it is certain that this is at least one of the predisposing causes of the disease. It is also found in wheat and corn germ, yeast and the other sources of the vitamin B₁.

Vitamin C. The practice of introducing orange juice into the diet of infants represents perhaps the oldest attempt on our part to supply an acces-

sory food factor in our feeding cases. Indeed orange juice and the juice of other citrus fruits are rich in this vitamin, but other sources which have proven to be equally rich have been discovered in recent investigations. As has been previously mentioned, for example, the lime has always been regarded as a rich source of vitamin C, but we have been shown recently that lemons are superior. Going further than this, Kohman, Eddy and Gurin¹¹ have dispelled the belief that carrots, celery and head lettuce are superior as sources of vitamin C. It has also been discovered by Zilya¹² and his coworkers that whereas fruits and vegetables are generally effective in curing and preventing scurvy, there are not only marked differences between various species but also between varieties within a species. It is well therefore to vary the routine of utilizing orange juice or tomato juice in the prevention of scurvy and occasionally introduce other sources of this vitamin such as fresh fruit, lemon juice, cooked apples, and green vegetables. The latter, however, should not be regarded as potent a source of this vitamin as the juices of citrus fruit or tomato juice.

Astonishing as it may seem, scurvy is still encountered in large clinics, more often than would be expected in view of our possession of specific means to prevent it. Recent studies, however, have also shown that vitamin C is an important factor in the development of the teeth and in the prevention of early tooth decay.

Vitamin D. Of all the vitamins which have been discovered, the fat soluble vitamin D is the one which has received the greatest amount of study. It has now fully earned the title of the anti-ricketic vitamin. For many years cod liver oil was regarded as the principal source of this vitamin, but independently of each other, Hess¹³ and Steenbock¹⁴ and their associates began experiments that showed that various foods, such as oils, milk, cereals, flours, green vegetables and human and calf skin, etc., could be endowed with specific anti-ricketic properties merely by subjecting them to ultra-violet radiations. About the same time Huldschinsky was working to the same end in Germany.

The important linking of these two potent factors concerned in nutrition opened up the possibility of eliciting the real nature of vitamins. Hess and Weinstock and associates¹⁵ and Windaus and Hess,¹⁶ by means of chemical analysis and spectral absorption tests, determined that it

is ergosterol, a sterol closely allied to cholesterol, which is activated by the ultra-violet rays in this remarkable way.

With the revelation of the fact that ergosterol could be activated by ultra-violet radiations, it naturally seemed possible to create a substance which could contain anti-ricketic properties in a highly concentrated form. This ambition was soon realized with the perfection of irradiated ergosterol prepared according to the requirements of the Alumni Research Foundation of the University of Wisconsin. The Council on Pharmacy and Chemistry of the American Medical Association considered it desirable to designate this substance viosterol.

In a short while, however, it was realized that although viosterol supplied the vitamin D in a concentrated form, it was still desirable to use the vitamin A in conjunction with the vitamin D.

Vitamin D deficiency is probably more easily demonstrated in experimental animals than in any other way.

Of the experiments which have been performed none have been of greater interest than those of the Mellanbys¹⁷ of England. After a study lasting five years they proved that puppies, in which rickets had been induced by the deprivation of fat-soluble vitamins, showed imperfect dentition. The teeth of such animals were small and irregular, and frequently discolored, while histologic examination showed that the development of both dentine and enamel was defective. Further research established beyond doubt that this imperfect dentition in puppies was due to the lack of vitamin D. This conclusion was supported by examination of the deciduous teeth of children.

No fewer than 1,036 of such teeth were examined histologically. The general belief has been that the majority of deciduous teeth are normal, but Mrs. Mellanby showed that by far the greater number of them present signs of defective development of dentine. Moreover, the teeth obtained from the dental clinic were more defective than teeth from children of middle-class families. This fact supported the view that defective dentition was due to a diet deficient in fat-soluble vitamins, for one of the chief faults in the diet of the lower classes is the inadequate supply of animal fats. Recently a report of the continuation of this study was made by Mrs. Mellanby and Pattison. 18

One of the unique things about the vitamin D is the fact that it may be introduced into the body otherwise than through food. Just as ergosterol and other foodstuffs are capable of acquiring antiricketic properties, so can the body. The value then of sunshine in nutrition, especially in the prevention and cure of rickets, is so thoroughly established and has received so much comment that it requires little mention here.

Vitamin E. This is a fat-soluble vitamin otherwise referred to as the anti-sterility vitamin. It is essential for reproduction. While lack of vitamin A causes failure of ovulation, the lack of Vitamin E causes failure of placental function. It probably is stored to a limited extent and the best sources are vegetable oils and fresh lettuce. Of all the vitamins, this one seems to have attracted the least interest because of the belief that it is acquired by the average adult in the most ordinary of diets.

Conclusions. These, then are some of the conspicuous contributions to the vast amount of literature which has accumulated during the past decade on nutrition. Notwithstanding the fact that greater progress has been made in the present generation in nutrition and the prevention of nutritional deficiency diseases, there are many problems which remain to be solved. Any assumption that the study has reached a point beyoud which there is little possibility of progress as was believed at the beginning of the century, can be considered nothing but a delusion. Almost every day research penetrates another veil of mystery surrounding the vast number of problems connected with nutrition, and it is reasonable to suppose that this will continue. Certainly no one today would be so bold as to make the assertion accredited to the great surgeon Syme of Edinburgh who told Lister that it was very unfortunate that he was coming into surgery at a time when there was no possibility of advancement of the art. In any event, our knowledge of the food accessory factors seems to justify the following impressions:

- 1. The vitamin A is capable of increasing resistance to infections, especially of the upper respiratory system and the intestinal mucosa. It is necessary as an adjunct to the vitamin D in the cure and the prevention of rickets.
- 2. Too little attention has been paid to the importance of including vitamin B in the diet of infants and young children. Adequate evidence seems to indicate that it is capable of overcoming anorexia, loss of weight and evidence of anemia.
- 3. The prevalence of scurvy in certain large centers does not seem to be fully appreciated.

There seems to be a slight increase in its incidence which may be explained by economic conditions, notwithstanding the fact that orange and tomato juice have been advocated for many years as a routine addition to the diets of infants.

- 4. Vitamin D in the form of irradiated ergosterol has justly earned the designation, the antiricketic vitamin. The addition of vitamin A, however, improves its effect.
- 5. The Mellanbys seem to have presented incontrovertible evidence that carious teeth are frequently the result of the same factors responsible for the development of rickets, but the importance of vitamin C in the prevention of carious teeth cannot be underestimated.
- 6. Rickets is more prevalent than has ever been supposed before modern methods of eliciting it were perfected. It is believed that the present econonic condition will be responsible for a further increase.
- 7. It has been shown that rickets can be very much reduced by improving the diet of the mother during the pre-natal period and period of lactation, although rickets is chiefly a post-natal condition. Advantage should be taken of all the newer knowledge of nutrition in our post-natal care.

One of the discoveries of the White House Conference on Child Health and Protection was the fact that we were in possession of a large amount of worthwhile information to assist us in dealing with problems of nutrition, but that we were utilizing only a small part of this information at the present time.

If I have in this comparatively brief discussion of our newer knowledge of nutrition awakened an interest and encouraged vou to seek further information, I will be very much gratified.

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BRONCHIAL ASTHMA AND ALLERGIC RHINITIS*

Review of Literature and Notes on Occur-RENCE IN SOUTHERN FLORIDA.

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Many victims of bronchial asthma trek their way to southern Florida seeking surcease from their affliction during the long winter months, so it behooves us, as physicians, to find out what opportunities for relief are afforded by this widely heralded winter resort.

In this paper I wish to review some of the current ideas and facts pertaining to asthma and allergic rhinitis, and to discuss fifty cases observed in the Miami area.

Definition and Etiology: That asthma and allergic rhinitis are symptom complexes which are manifestations of fundamental allergy in an individual is generally acknowledged by most clinicians dealing with this type of illness. However, one may well paraphrase the song writer and ask, "What is this thing called allergy?" Though the meaning of the term is subject to differences of opinion, for practical purposes the term may be applied to conditions of specific hypersensitiveness with the exception of anaphylaxis in lower animals. The characteristic symptom complex must be produced by contact with a particular agent foreign to the body and must be abolished when this contact is interrupted. Rackemann¹ has defined additional characteristics of allergic individuals as follows: The presence of other manifestations of allergy in the same patient, a positive family history of allergy, positive skin tests and eosinophilia.

The usual argument produced to rout the conception of asthma being an expression of allergy is the fact that attacks may be excited by such a

^{*}Read before Dade County Medical Society, November 7, 1930.

variety of non-specific influences such as nasal irritations, emotional and psychic disturbances, atmospheric and barometer changes, over-exertion, fatigue, over-eating, flatulence, menstruation and pelvic disorders.

Baldwin² has recently emphasized the role that vagus nerve stimulation may play in the mechanism of attacks of asthma brought on by these nonspecific stimuli, on the basis of conditioned reflex Cooke3 groups these together as "reflex asthma" and states that this heterogeneous group of excitants acts only in individuals in whom the bronchial mucous membrane and smooth muscle fibers of the bronchi have acquired the habit of reacting as a result of previous attacks due to true allergic influences. The fact that many of these cases no longer respond to non-specific stimuli after the primary specific reaction has been treated is the best proof that non-specific influences are not the fundamental causes of the asthma.

The hypothesis that hayfever and asthma is a type of alkalosis has been advanced by Beckman4. As presumptive evidence he reminds us that asthma or hayfever may disappear in diabetes, starvation, pregnancy, acute infections, sea voyaging and high altitudes, all of which conditions are accompanied by a degree of acidosis. believes that the effects of calcium therapy may be explained by a shift in the blood acid base balance toward the acid side, thus overcoming an alkalosis. On theoretical grounds, these various facts may be easily criticised, but it is interesting to note that he can quote 67 per cent of 237 cases of hayfever relieved of symptoms by the simple administration of nitrohydrochloric acid internally. This hypothesis is of further interest in connection with the results reported by Brown⁵ in the treatment of food sensitization. Brown used at first hydrochloric acid, and attributed his beneficial results to a digestant action on the ingested protein in the diet. He later used citric acid, with equally good results. Sansum⁶ even advocated the use of large quantities of citrus fruits, in place of citric acid, stating one can obtain in the stomach a hydrogen-ion concentration sufficiently high clinically to take the place of hydrochloric acid. Obviously, if citric acid when metabolized produces a shift toward alkalosis, then the results obtained from its use are an argument against the condition of alkalosis being productive of symptoms of hayfever or asthma.

In establishing a diagnosis of asthma or allergic

rhinitis, it is of prime importance to obtain a complete history as in some cases the etiological factors in the condition will be indicated better than by skin testing. The environment should be described in detail. So-called colds and recurrent attacks of bronchitis, and even pneumonia, in children or infancy may frequently be interpreted as expressions of allergy in an individual who presents in adult life a frank bronchial asthma. Close interrogation is needed frequently to disclose whether a patient's symptoms are seasonal or perennial in type. The relation of symptoms to the ingestion of various foodstuffs should be minutely inspected. The inclusion of all these facts in the history is of extreme importance, as every allergist has emphasized, and will prevent making foolish mistakes.

ANALYSIS OF FIFTY CASES

I have made an analysis of fifty unselected private cases of asthma and allergic rhinitis that have been under my observation during the past four years. Twenty-one had both asthma and allergic rhinitis, while twenty-three had asthma only, and six had allergic rhinitis only.

Agc: One of this group was eight years of age, six were in the second decade, twenty-one were between 20 and 40 years, sixteen were between 40 and 60, while the remaining six were over 60 years of age.

The age of the initial attack was under ten years, however, in five cases. As a general rule asthma is acquired in early life, while true hay-fever is not manifest until later life. However, it is known that many children may exhibit mild symptoms of hayfever and go for years undiagnosed. Asthma may begin at any age of life.

Sex and Race: There were 22 males and 28 females, but in any large series the proportion is about equal. These patients were all American born, excepting one family of four from the Bahamas.

Heredity: In only twenty-five patients was a record made concerning the question of antecedent asthma or hayfever in the family. Eleven cases or 44 per cent gave a positive history of allergy in the parents which corresponds to the figures of 48 per cent and 60 per cent given by Cooke³ and Balyeat,⁷ respectively. In regard to heredity, it has been demonstrated by Cooke, Balyeat and others that hypersensitiveness is transmitted as a dominant characteristic according to the Mendelian law, and that the offspring of allergic individuals are not born allergic, but that

the age at which allergy becomes manifest is earlier if both parents have a positive history; in other words, the closer the relationship and the more complete, the earlier is the manifestation. An outstanding example of the influence of heredity is shown in the family mentioned above born in the Bahamas. Four members of this family are under my care because of asthma or hayfever. The mother, aged 47, and three of her four children are affected. Furthermore, her own mother and a paternal aunt and uncle had asthma.

Effect of Climate and Season: Although twenty-one patients had their initial attack while in southern Florida, most of them also experienced asthma or allergic rhinitis when in other states at later dates. Careful questioning did not bring out any evidence on the whole that they were more subject to attacks in the Miami area, as only two patients could definitely make the statement, and at least three others were sure their winters here gave them fewer days of symptoms. Thirty-seven of the fifty cases were unable to state that one season of the year affected them more than another, whereas ten patients had their symptoms mostly in the fall and winter (October to March, inclusive), and three others were free from symptoms in December, January and February only.

Complications and Associated Diseases were as follows: Menopause 2, eczema 1, scleroderma 1, cholelithiasis 2, hypertension with myocardial damage 5, arteriosclerosis and cataract 1, diabetes 1, chronic nephritis 2, chronic nephritis and pulmonary tuberculosis 1, pulmonary fibrosis 19, pulmonary fibrosis with myocardial damage 3, bronchiectasis or pulmonary abscess 1, congenital-ankylosis of jaw 1, Sydenham's chorea 1, irritable colon 5. Only one patient had a possible history of syphilis, and in this case the Wassermann was consistently negative. However, neoarsphenamine was used because of a complicating Vincent's infection. In twenty-six cases the Wassermann was negative, and not determined in the others.

One or more of the accessory nasal sinuses was diseased in 16 cases, but in only five was the sinus operated, and in 7 cases septum resection was performed. In 9 patients the condition of the sinuses was not recorded.

Skin Tests: Positive reactions to scratch or intradermal atopens were found in 34 cases, but in 9 cases testing was either incomplete or not done at all, and in only 7 cases were the skin tests entirely negative. Usually more than one positive reaction was obtained. (See Table 1.)

Table 1.

SUMMARY OF POSITIVE SKIN TESTS IN 41
PATIENTS.

ATOPEN REACTION	NS	ATOPEN	REACTIONS
Short ragweed	9	Chicken feather	s 4
Wheat	8	Horse dander	4
Rabbit hair	7	House dust	4
Baccharis	6	Timothy	4
Natal grass	6	Egg (whole)	4
Dog hair	6	Kapok	4
Orange	5	Bermuda grass.	4
Beet	5	Goose feathers.	4
Cat hair	5	Milk	4
Giant ragweed	5	Corn	4
Duck feathers	5	Orris root	4
Sheep wool	5	Cattle hair	4

Reactions to other substances occurred less than 4 times among the group.

An incomplete though practical pollen survey of the Miami area was made with the cooperation of Mr. O. C. Durham, covering a two-year period. The complete report of the survey will be published elsewhere but note should be made that there is very little ragweed pollen found in southern Florida, so that it is safe to say that this area is safe for patients sensitive to ragweed.

Basal Metabolism: This determination was made in only 8 cases, and ranged from -10% to -29%, excepting one patient with plus 11 per cent.

Blood Calcium: In seventeen cases the serum blood calcium was determined by the Kramer-Tisdall permanganate titration method, and was found to range from 10 to 13 mg, per 100 cc. of blood, which is within the normal range. It is of interest that Ramirez⁸ found in a large series most blood calcium determinations within normal range, and in the cases where it was below 10 mg. per 100 cc. of blood, he could note only temporary improvement in the allergic symptoms by means of calcium therapy, even in the cases where the blood calcium was raised to normal levels. Furthermore, more recent studies by Greenberg and Gunther⁹ of the diffusible calcium present in the blood in allergic subjects have failed to show any definite tendency to a lowered calcium.

Eosinophilia: An eosinophilia ranging from 9 to 23 per cent appeared in the blood of five patients, while in five others there was no increase, and in the balance it was not recorded. In a few patients eosinophiles appeared in the sputum. It should be borne in mind that eosinophiles may appear in the nasal secretions, and even in the conjunctival secretions in an allergic subject.

TREATMENT AND RESULTS

Various measures of treatment were followed in these patients. In discussing the results of treatment, the word "cured" is not used, but ten cases were classed as obtaining good results, and 19 obtained partial relief. No treatment was given 8 patients for various reasons. In five others the results of treatment are not known at this time, due to insufficient time of treatment. In 7 patients the treatment was of no avail. Four patients died while undergoing treatment.

Pollen desensitization was less frequently needed than would be expected were it not for the facts produced by our local pollen survey. Grass pollen (Bermuda and Johnson) desensitization produced good results in four patients and fair results in three others.

Elimination of offending Allergens: The simple elimination of rabbits from the environment produced a good result in one patient who was markedly sensitive to rabbit hair extract. Another patient was sensitive to wheat only, and lost her cough when all wheat was removed from the diet.

The elimination of foods which showed a positive skin test together with the use of a pollen air filter produced an excellent and immediate rsponse in one patient with asthma of seven years' duration. Three patients have shown a fair amount of improvement by the use of diets in which the common symptom producing foods were left out. The use of Rowe's elimination diets¹⁰ was a factor in determining what were the offending foods, even when negative skin tests were obtained.

Vaccine Therapy: This measure was not used alone, but in combination with other measures, so it is difficult to estimate its true worth. Usually autogenous vaccine was used, the different organisms included being determined by the response to skin tests with the separate antigens prepared from the sputum. Most allergists are agreed that in cases of asthma with respiratory infection (bacterial asthma), the use of an autogenous vaccine is of definite benefit. In two cases good results were secured by the use of a streptococcic vaccine prepared by Dr. E. C. Rosenow supposedly for influenzal infections. Though other measures were used, the response to treatment in these two patients seemed to begin only when the vaccine was started.

Surgical Treatment: Removal of nasal polyps and surgical eradication of sinus infections, together with the use of vaccines produced a fair degree of relief in six patients. In trying to estimate the value of removal of focal infections and other disturbances of the nose and throat, Rackemann and Tobey¹¹ reviewed the data of 1074 asthmatics, 28 per cent of whom had operations on

the nose and throat without regard to the cause of the asthma as found. They suggest that the local lesions of the nose and throat may develop from the same fundamental cause as the asthma itself. They found the gross results of treatment disappointing, affording permanent relief in about 5 per cent of cases. Hansel¹² has made a detailed study of the histopathologic changes occurring in the nose and sinuses in allergy, and he concludes that nonsuppurative or hyperplastic sinusitis should be considered as allergic sinus disease until proved otherwise, and should be treated conservatively and in conjunction with the treatment for the allergy. But, he also found that surgical treatment is frequently indicated to restore function in the nose and eradicate infection. (He found the consensus of opinion is that bacteria are secondary invaders). Radium should be used to control edema, hyperplasia and polypoid formations.

X-ray Treatment: X-ray treatment to the chest and spleen was used in five stubborn cases of asthma without notable improvement except tempatients with productive cough were given iodides has had few advocates and was used empirically.

Medical Treatment: All patients were taught the proper use of adrenalin and ephedrine, and patients with productive cough were given iodides if tuberculosis had been carefully excluded.

Calcium preparations were given empirically to some cases, either alone or coincident with injection of parathormone (parathyroid extract-Collip) in an effort to alter the blood calcium concentration. Otherwise the only drug commonly employed was aspirin.

SUMMARY

- 1. Some of the recent literature pertaining to bronchial asthma and allergic rhinitis has been reviewed.
- 2. Fifty cases observed during the past few years in Miami area reveal no striking differences from cases studied in other parts of the country, except the lowered incidence of strictly "pollen cases."
- 3. The Miami area is safe for ragweed sensitive patients.
- 4. An attempt has been made to evaluate the various forms of treatment.
- 5. Only ten cases or 20% obtained relief classified as "good", under varied forms of treatment, while 19 cases or 38% obtained "fair" results.

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ENDOSCOPY*

AN AID IN THE DIAGNOSIS AND TREATMENT IN DISEASE OF THE THROAT AND THORAX.

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HISTORY

Bronchoscopy is a little over thirty years of age. In 1897, Gastor Killian removed a foreign body from a bronchus. In 1898, the first bronchoscopy was done in the United States by Algernon Coolidge, Jr., a professor of Harvard Medical School working at the Massachusetts General Hospital. He used an open urethroscope, a head mirror and reflected sunlight and removed through the already present tracheotomic fistula a portion of a hard rubber tracheotomic cannula from the right bronchus of a man aged 22 years.

A distally lighted bronchoscope was developed about 26 years ago, and since that time it is estimated that over two hundred thousand endoscopies have been done in the United States.

In the early days of bronchoscopy, the procedure was used almost exclusively for the removal

of foreign bodies. External surgery for foreign bodies in the large bronchi near the root of the lung was attended by such high mortality that bronchoscopy was welcomed. External surgery was resorted to only at the periphery of the lung and after abscess formation. In those days bronchoscopy was attended with considerable mortality, but its mortality was much less than that of thoracotomy. Perfection of the technic, the development of team work, the elimination of a general anesthetic and the solution of the mechanical problems, has brought bronchoscopy to such a degree of perfection that 98 per cent of foreign bodies may be removed through the bronchoscope with a mortality of but little over one per cent.

When it was found that practically no mortality was attached to the mere insertion of a bronchoscope into the bronchi, the development of its use in pulmonary disease of other than foreign body origin came rapidly. At present two per cent of the endoscopy represents foreign bodies, 98 per cent being for the diagnosis and treatment of disease.

Clerf, writing on "The Progress of Endoscopy," states it has become apparent during the last few years that the recognition of the importance of bronchoscopy for diagnosis and treatment in disease has resulted in an enormous increase in the proportion of this type of case as compared with those in which a foreign body is involved. Chevalier Jackson believes the reason for the phenomenal success of bronchoscopy in disease is the restoration of the defensive power of the lungs. Bronchoscopic researches have demonstrated that the deeper bronchi are practically sterile, and that the bacteria are increasingly numerous as the larynx is approached. As bacteria laden atmospheric air necessarily reaches the alveoli, the observation justifies the inference that the defensive power of the lung destroys the bacteria. Two obvious elements in this defensive power are the cough reflex and the ciliary action. It is by assisting in this defense, by bronchoscopic attack on the invading host from the rear, that the wonderful results of bronchoscopic aspiration in early suppurative pulmonary disease seem to be ob-

In dealing with the subject of bronchoscopic suppuration, Dr. Jackson says, "It is probable that drainage of superficial foci of suppuration was done with a flint in the hands of the caveman. It is reasonably certain that this was done by the ancient Peruvian. Hippocrates preached and prac-

^{*}Read before the annual meeting of the Florida Midland Medical Society, Orlando, October 8, 1930.

ticed drainage of pus and since his time drainage has been fundamental in surgery. Bronchoscopic aspiration is the same in principle: the new thing about it is the discovery that with the bronchoscope, suppurative foci can be drained through the mouth harmlessly and without general anesthetic. There is an abundance of clinical evidence at the Bronchoscopic Clinic justifying my opinion that the fundamental factor in all pulmonary pathology is impaired defensive power of the lung due to impaired drainage and deficient aeration. By bronchoscopic drainage we take the load off the cilia and restore spontaneous drainage; we reestablish the defensive power of the lung. I may be a visionary, but when I see the massive atelectasis, et cetera, I cannot but feel that the first resort in the future will be not to opiate and other antibechics, but to bronchoscopic aspiration, to restore spontaneous drainage instead of hindering it by the continued administration of drugs that paralyze the cough reflex."

Looper summarizes his article on Endoscopy: The laryngoscope, bronchoscope and esophagoscope should be more generally used as a diagnostic aid, and the fact should be impressed on the medical profession that endoscopy has a much broader field than merely for foreign body cases. It is surprising how many laryngologists do not even own a direct laryngoscope and do not attempt the simplest endoscopic examination. As much skill is required in removing foreign bodies, this field should be left to those who are particularly qualified, but the average specialist should take advantage of the usefulness of per-oral endoscopy as an aid to more accurate diagnosis in lesions of the upper air and food passages.

CARCINOMA

It is now generally acknowledged that carcinoma of the bronchus is more frequently observed than formerly. If this represents an actual increase or whether it is a relative increase due to more accurate diagnostic methods can not be definitely determined.

The clinical picture is so varied that no definite symptom complex is said to be characteristic. If any improvement is to be accomplished in the treatment of these cases, it must depend upon more early diagnosis.

Jackson and others reported fourteen cases in which the diagnosis was made bronchoscopically and corroborated by histologic study in which the diagnosis could not have been made by any other means. They consider bronchoscopy as the method of diagnosis that is most certain and one that should always be employed.

In conclusion, the writers state that the evidence suggest that carcinoma of the lungs, which in the great majority of cases originates in a bronchus, is increasing in frequency.

These bronchial tumors appear to have a relatively low malignance; hence, the hope that an early diagnosis and intensive roentgen-ray and radium therapy may be effectual in at least prolonging life.

Shall reports a diagnosis of bronchial carcinoma which was positively made by bronchoscopy and biopsy in five cases. He concluded that primary carcinoma of the bronchus is not an uncommon disease. Bronchoscopy offered the best means of establishing an early diagnosis of a malignant condition of the bronchi. Patients with obscure conditions of the chest should have the benefit of close cooperation of the thoracic surgeon, internist, roentgenologist and bronchoscopist, acting as a group.

Vinson, Moeisch and Kirklin reported seventyseven cases of primary cancer of the lungs. In twenty-nine of these, a positive diagnosis was made during life by the examination of tissue removed from the bronchus. These observations confirm the statement now generally accepted, that bronchoscopy is the safe and most exact method of making an early diagnosis.

LUNG ABSCESS

In lung abscess the bronchoscope is again an important factor in the diagnosis and treatment of these cases. In treating cases where the diagnosis has been made early the results are almost spectacular. I have seen cases clear up rapidly after two or three bronchoscopic treatments. In cases of long standing many treatments are necessary.

Clerf, in reporting a series of seventy-seven cases, states that in thirty-eight patients that were cured, the average number of bronchoscopic treatments was sixteen.

He concluded: "Bronchoscopy is indicated as a diagnostic measure in every case of pulmonary abscess in which there is a question in diagnosis. Bronchoscopic aspiration, as a part of the conser-

vative form of treatment, should be instituted early in the disease unless contraindicated; in the hands of an experienced bronchoscopist contraindications are few. No definite rules can be laid down with regard to length of time bronchoscopy should be continued; every case of abscess of the lung should be individually considered by the internist, roetgenologist, surgeon and bronchoscopist to determine the form of treatment to be employed."

ASTHMA

Unquestionably the diagnosis and treatment of asthma has been greatly augmented by bronchoscopy. Ramirez and St. George believe that bronchoscopy is of undoubted value in the so-called non-allergie forms which are associated with chronic bronchitis and bronchorrhea. The benefit derived is not from the removal of the thick, adherent nucus and the bronchial medication alone, but also from the vaccines prepared from the bronchoscopically removed secretions free from oral contamination. Autogenous vaccines prepared in this manner seem to be more effective than those prepared from the sputum.

Before an asthmatic patient is accepted for bronchoscoptic treatment, systematic studies should be made to elicit all possible etiological factors. The investigations should include a roentgen-ray study of the chest and a rhinologic examination as well as the usual allergie tests.

Clerf believes that certain patients with asthma, especially those in whom there is a chronic tracheobronchitis or definite suppuration in the lung, respond favorably to the bronchoscopic aspiration of the secretion.

Bronchiectasis

Bronchiectasis is another lung condition that must be diagnosed early if we are to do anything for these unfortunates. When of long standing they can be improved but relapses are frequent.

The means to establish an accurate diagnosis of bronchiectasis in its early stages are the uses of iodized oil and pneumography. There are various ways of getting it into the bronchi, but the bronchoscope has the advantage of inspecting the field, aspirating the secretion and placing the oil in whichever bronchus is diseased.

There is unquestionably a marked relationship in the etiology of bronchiectasis and disease of the nasal accessory sinuses. No study of a patient with bronchiectasis is complete unless a carful and painstaking examination of the nasal accessory sinuses has been carried out. There are abundant clinical observations supported by experimental studies which indicate that chronic diseases of the nasal accessory sinuses is a factor in the production of bronchiectasis. Clerf writes: "Examination of a patient complaining of chronic cough with or without expectoration is never complete until a careful study of the nasal accessory sinuses has been carried out; a negative opinion on sinus disease should not be given until every necessary diagnostic means has been exhausted. Every patient complaining of unexplained chronic cough or in whom a questionable diagnosis of bronchiectasis has been made should receive the benefit of diagnostic bronchoscopy and pneumographic studies. Irrespective of the etiologic relationship, treatment for a co-existing bronchiectasis and suppurative sinusitis is not complete unless it is applied in both conditions."

There is so much that can be written that I have purposely left out saying anything about the esophagus for fear the paper would be too long.

Conclusions

- 1. For bronchoscopic diagnosis it is necessary that the eye be trained to recognize the color, form and movement of the bronchi in health, so that any departure from the normal is at once recognized.
- 2. Without question there is a great and important field for per-oral endoscopy in examination and treatment of disease of the throat and thorax, and should always be used where indicated.
- 3. Diagnosis can often be made with the bronchoscope of a thoracic disease that can not be made by any other means. This is especially true of beginning bronchial neoplasms, foreign bodies, abscess of the lung and bronchiectasis.
- 4. It is the best conservative treatment for lung abscess, and the percentage of cures are higher than by any other form of treatment used today.
- 5. There is no shock, a mortality almost nil and in the hands of an experienced bronchoscopist, contraindications are few.
- 6. Every patient complaining of an unexplained chronic cough or in whom there is a questionable diagnosis, should receive the benefit of a diagnostic bronchoscopy.

CHRONIC ENDOCERVICITIS*

JAY A. POWELL, M.D., West Palm Beach.

Around the subject of endocervicitis a very extensive literature has accumulated. So much has been contributed to this subject that we often wonder if there is anything fresh or important left to be said. Yet there is a general belief that no small part of what has been written requires revision in the light of modern inquiry as conducted by the various investigators. The wealth of teaching in the text-books is too often impersonal, and represents a legacy flowing from one's ancestors rather than a fortune newly won by hard endeavor.

Endocervicitis as a clinical entity was not recognized until bacteriological studies demonstrated that the endometrium is usually free from bacteria and the pioneer work of Billings and Rosenow, establishing the possible dangers from chronic foci of infection, taught us the importance of eliminating chronic infection from the cervix. The demonstration of joint lesions in rabbits injected with organisms grown from chronically infected cervical glands of a patient suffering from arthritis shows definite relation chronic endocervicitis bears to systemic conditions,

Since the pathology of diseases of the cervix is based so largely on the histologic peculiarities of that organ, it might be well to review briefly its structure and function, particularly in relation to those of the uterine body. Embryologically, the cervix is developed from the second portion of Muller's duct, union being effected at the internal os. The cervical mucous membrane is composed of complicated racemose glands which empty through small ducts into the cervical canal; their lining epithelium is of the high, cylindric, goblet cell type, and their secretion is true mucus. In addition, the cervical mucosa is thrown into definate folds radiating from a central line, the whole constituting the so-called arbor vitae. Toward the external os, the ciliated epithelium undergoes transition into the laminated type which covers the intravaginal portion of the cervix; toward the internal os, the glands become less arborescent and the whole cylindric epithelium is lower, so that a transition is gradually effected into the corporeal endometrium, which consists of simple glands lined with cuboidal epithelium, lacking the corrugations characteristic of the endocervix,

and secreting a serous instead of a mucus discharge.

Equally important is the lymphatic structure of the cervix and the uterine body. The lymph current may be traced from its origin in the cervical and corporeal mucosa through minute, funnel-shaped ostia, directly to the myometrium, where it branches into an extensive capillary net which penetrates every bundle and fascicle of the entire uterine musculature, later draining into the main collecting channels which course parallel to the uterine and ovarian blood vessels at the base and top of the broad ligament.

Functionally, the cervix acts merely as a passive communicating channel to the vaginal outlet.

Careful laboratory studies, culminating in the work of Curtis, have proved quite definitely that the internal os acts as a barrier against practically all invading organisms except the gonococcus, so that while infection of the endocervix is frequent, infection of the corporeal endometrium is rare and is practically never of intrinsic origin. The comparative histology and function of the two structures make these facts obvious, and it need not be emphasized that the complicated structure of the cervix, particularly in the light of its frequent exposure to trauma and external infection is an ideal medium for the growth of bacteria, or that its lymphatic system furnishes an ideal route for the upward extension of local infection.

The causation of chronic endocervicitis is far from clear. A large percentage of the cases are no doubt due to specific infection, some from di-"ect contact and some from a childhood infection which was possibly so mild that it passed unnoticed then, but, after lying dormant for years, was fanned into activity at a later date or paved the way for another type of infection, as is frequently the habit of the gonococcus. The normal external os has to some extent the faculty of the internal os of prohibiting the entrance of pathogenic bacteria; but when injuries occur, such as lacerations from childbirth or, less frequently, from careless instrumentation, this is no longer the case, and the gaping, open os and the exposed mucosa due to the resulting eversion offer an easy avenue of access for whatever bacteria may be present. Whether the colon bacillus figures through a blood stream infection or by an ascending route we do not as yet know, but it is a significant fact that a large number of these patients give a history of extreme constipation. Predisposing causes are to be found in any general con-

^{*}Read before the Palm Beach County Medical Society, West Palm Beach, 1926.

dition, such as anemia or tuberculosis, which, by lowering the patient's resistance, makes her an easy prey to bacteria which under normal conditions would hardly be pathogenic.

Practically all types of bacteria may be identified in chronic endocervicitis, but certain types are predominant. Of these, the gonococcus is the most common, although frequently it cannot be identified in spite of repeated tests and exposures, because of its tendency to burrow deep into the cervical tissues and remain dormant for years, or because it may itself have died out and have been replaced by a later infection of a different type. The streptococcus, the staphylococcus and the colon bacillus are generally agreed to be next in order of frequency, and mixed infections are not uncommon.

Pathology—The gross picture of endocervicitis may differ in intensity, but is for the most part typical. The cervical mucosa appears red, swollen and more or less everted, and there are circumscribed areas of glandular proliferation about the external os. The columnar epithelium of the canal may have pushed itself out on the vaginal aspect of the cervix and it may have over-grown or completely replaced the stratified epithelium normally present, producing the so-called erosion, which, as has been repeatedly pointed out, is in no sense an ulceration but merely new cell formation resulting from the proliferation of the lymphoid tissue within the canal. Hypersecretion of the cervical glands, which results both from the prolonged vaginal contact and from the distorted structure, results in turn in hyperplasia of the cervical connective tissue. The occluded glands, which may be actually plugged by tenacious mucus as well as by the overgrowth of the squamous epithelium, or by hyperplasia of the periglandular tissue, and the cyst formation, which is not infrequent, add to the hypertrophy, so that the cervix may be several times its normal size. The microscopic picture, which concerns us only incidentally, will vary from mild inflammatory changes in the stroma and excess of glandular tissue to marked cystic changes and even multiple abscess formation.

Pelvic manifestations are more usual in the ovaries than in the tubes, and parametritis is frequent, particularly in association with posterior cellulitis. It is difficult to estimate what percentage of these lesions, especially the degenerative changes of the ovary characterized by an insidious development, could be traced to an ascending

lymphangitis; but, in view of the complicated lymph system that I have already described, it is obvious that a fair number of such infections are of primary cervical origin.

The symptoms of endocervicitis are varied and are often complicated by the fact that, when the patient reaches us, we are dealing not only with endocervicitis but also with associated or resulting pathologic changes that may entirely overshadow the original lesion. The most constant symptom is a leukorrheal discharge, usually odorless, varying in quantity and varying also from a thin, mucoid secretion to a highly colored, purulent one, as is nearly always the case in gonorrhea, but always characterized by its tenacity. Menstrual derangements are not uncommon, being the result of a secondary hyperplasia, a circulatory stasis, or a secondary ovarian involvement. Backache is not ordinarily present unless there are associated displacements or parametrial involvement, particularly posterior cellulitis, with extension to the uterosacral ligaments. Sterility is a frequent complication, owing to the plugging of the cervical canal by tenacious mucus or the thickened cervical mucosa, or the destruction of the spermatozoa by purulent secretions. Constipation is frequent, and systemic manifestations will vary according to the severity of the disease.

Since the leukorrheal discharge and the gross cervical picture are in most instances pathognomonic, diagnosis does not ordinarily present many difficulties. Tuberculosis and syphilis of the cervix, both comparatively rare conditions, may be differentiated by the history and the general physical and laboratory examinations, as well as by the fact that normally in both the tendency is toward destruction of tissue rather than proliferation. Smears should always be made and cultures if necessary, in an endeavor to identify the infecting bacteria, and in suspected malignant diseases, laboratory studies are essential for a differential diagnosis, which is imperative in view of the radically different treatment necessary in each instance. It goes without saying that infection of the lower genital tract and of the upper pelvis should be carefully differentiated also.

The recognition that chronic endocervicitis is a menace to the future health of the patient has led to renewed efforts to secure an effective cure. Thus far very little has been accomplished in the way of prophylactic treatment. Local applications with silver nitrate, tincture of iodine, etc., have no doubt been useful in certain cases, but the

results have more often been unsatisfactory.

Some brilliant results have been reported by Rottenberg and Schwartz. In their technique the cervix is partly amputated or rather a hollowing out of the cervix, thereby getting rid of the proliferation and finally a reconstruction of a new canal. Some investigators, however, doubt the wisdom of such a procedure during the child-bearing period.

Favorable results have been reported from diathermy, while radium in small doses has many staunch followers.

I think when we consider the pathological changes found in cases of chronic endocervicitis, we realize that the treatment instituted must be to destroy or remove the abnormal proliferation of cell and restore the cervical canal to its normal relation if it is to be effective. For some time I have followed the technique described by Davis. After inserting a suitable bivalve speculum the mucous discharge is thoroughly removed with cotton. A small cautery tip is placed firmly against the tissue to be destroyed and the current turned on. When a sufficient depth is reached. the tip is moved so as to make a line through the diseased tissue. In some cases it will only be necessary to cauterize the glands near the external os, in others the disease will extend to the internal os. If, at any time, the patient complains of discomfort, the current control is released and not applied again until she is comfortable. This process is repeated until a sufficient number of cautery lines have been made. Cysts are destroyed in a similar manner after puncturing with the heated tip. An effort is made to reach the depth of the gland so as to destroy the chronically diseased tissue. Most cases of endocervicitis may be treated in the office; the pain is slight and it is only in the very nervous patient, or one requiring very deep cauterization, that a general anesthetic is necessary. One thorough cauterization results in early relief of symptoms and there is complete healing in six or eight weeks. If, however, the treatment is superficial, a second may be necessary after four weeks.

After cautery treatment the discharge is increased for about ten days. The patient is warned that the next period will be more profuse than normal.

I find mercurochrome in 5% solution a useful germicide and is used at weekly intervals until healing is complete.

Women approaching or past the menopause are more liable to cervical cancer, and radical treatment may be indicated. Sometimes total hysterectomy is a conservative procedure provided the patient is a good surgical risk.

CONCLUSION

Endocervicitis is recognized as a distinct clinical entity.

The relation of chronic endocervicitis to systemic conditions has been definitely proven.

In chronic endocervicitis the tendency is a proliferation of tissue rather than destruction.

Chronic endocervicitis is often the forerunner of other pathologic changes in the pelvis.

Destroying diseased tissue with cautery causes early relief of symptoms.

MEETING OF THE FLORIDA DERMATO-LOGICAL ASSOCIATION

Chairman, C. A. Andrews; Secretary, J. F. Wilson.

The regular quarterly meeting of the Florida Dermatological Association was held in Tampa the week-end of October the fourth. Those in attendance were, Elmo D. French, Miami; J. L. Kirby-Smith and J. F. Wilson, Jacksonville; C. A. Andrews, W. C. Blake, R. G. Nelson and J. J. Saxton, Tampa.

During the morning hours there was a clinic at which were presented sixteen interesting and unusual diseases of the skin.

Following a luncheon given by Doctors Andrews and Saxton at the Hillsborough Hotel, there was a round table discussion.

Case No. 1.—Lupus Erythematosus. (Presented by Dr. C. A. Andrews)

M. R. S., white male, age 32, merchant. First seen on November 27, 1924. Duration, four months. He had at that time two typical lesions, one on left side of face and one near the outer canthus of the left eye. A diagnosis of lupus erythematosus was made and he was advised to have an infected tooth removed. Carbon dioxide snow was applied for five seconds.

Next seen on March, 1925, five lesions present. Kromayer light under pressure was applied to each lesion for two minutes. On April 13, 1928, he was seen by Dr. Kirby-Smith who suggested the use of gold sodium thiosulphate. He has had three separate courses of this drug of ten injec-

tions each. His skin was practically clear on August 4, 1930, but he has returned at this time with recurrence. This patient had a diagnosis of syphilis made by another physician, but I doubt if it is correct as I have never been able to corroborate it.

DISCUSSION

Dr. French: I agree with the diagnosis and believe tuberculosis is the cause in this case. Certain lesions about the neck have the appearance of sarcoid and lesions on the extensor surfaces of the forearms remind one of a tuberculid.

Dr. Saxton: There is some doubt as to whether it is psoriasis or lupus erythematosus. I would think that it is lupus erythematosus.

Dr. Wilson: It is a case of lupus crythematosus, but its resemblance to psoriasis is marked.

Dr. Kirby-Smith: I agree with the diagnosis of lupus crythematosus. It seemed to me when I saw this patient three years ago he had typical bat-wing lesions. We should investigate the tuberculosis origin thoroughly. The remarks that Dr. Saxton made brought to my mind that this case has the appearance of psoriasis and the configuration of syphilis and would suggest if possible that a biopsy be taken and a tuberculin test made.

Dr. Andrews (closing): Dr. Blake tells me that this man has active pulmonary tuberculosis and that the bacillus has been found in his sputum.

CASE No. 2.

SEBORRHEA AND EPIDERMOPHYTOSIS. (Presented by Dr. C. A. Andrews)

A. A. B., male, white, age —, dentist. This patient was first seen on March 18, 1926, and stated that he had this condition about 3-4 months.

The lesions at that time were located in the axillae, both groins, about navel, and some noted on his scalp, crust all over and particularly the hair margin in the region of the forehead.

The diagnosis at that time was both seborrhea and tricophuton infection. In my opinion they were both present.

The patient has been seen from time to time since the above date. He has been given various lines of therapy. Local applications with some quartz, and some X-ray. The quartz light apparently is most efficacious.

Seen June 15th, condition same.

The diagnosis was seborrhea of the head and epidermophytosis on the feet, genitals and rectum.

The lesions about the face are apparently healed at the present time. The one about the navel at

times presents question as to the diagnosis. Those on the genitals, I believe, are a ringworm infection.

Distribution: At present, on scalp, ears, genitals, about navel, inguinal folds and feet.

Treatment and results: Various local applications, some X-ray and some quartz. The quartz apparently most efficacious.

DISCUSSION

Dr. French: I would suggest investigating the man for anemia because of the color of his skin.

Dr. Saxton: Diagnosis agreed with.

Dr. Wilson: I agree with the diagnosis, but not with the treatment, and suggest sulphur, as a local application.

Dr. Kirby-Smith: I would propose that he be given definite instructions for the care and treatment of his feet. To control the immediate symptoms, I would suggest that he use hypo-sulphate of soda, put on three times a day. For purpose of controlling the itching, ultra-violet ray with some X-ray. Patient should be on a vigorous diet, excluding all fats and carbohydrates.

Dr. Andrews (closing): The man is one of our professional men here, whose profession is related to medicine and he was presented for therapeutic advice as to the case.

CASE No. 3—MORPHEA.

(Presented by Dr. C. A. Andrews)

Miss M. C., female, white, age 60, music teacher. Condition began in the summer of 1930. Patient consulted me on February 28, 1931. Lesions noted over thighs, abdomen and back. Description of dermatosis; classical picture of morphea.

DISCUSSION

Dr. Wilson: Frankly, I don't know what it is. It is not circumscribed as morphea is. It is probably due to glandular dysfunction.

Dr. French: Primary atrophy or secondary form following trauma syphilis or tuberculosis should be considered. Three typical patches of morphea, with their lardatious brawny centets and purple margins occur, and I favor this diagnosis. I would suggest a trial of thyroid gland product, by way of therapy.

Dr. Saxton: Concurring.

Dr. Kirby-Smith: I would diagnose scleraderma. Morphea is a circumscribed scleroderma. I suggest metabolism test and thyroid extract.

Dr. Andrews (closing): This case was diagnosed morphea, by Dr. Fox in the summer of 1930. It is an unusual case in my practice.

Cases Nos. 5 and 6.

Telangectasis—due to tricho treatment.

(Presented by Dr. C. A. Andrews) Miss H. G., age 28, white, clerk.

Mrs. D. L. H., white, age 31.

Both received tricho treatment for removal of superfluous hair. Description: Telangectasia and atrophy of the skin, affecting the lower part of the faces and the forearms of both patients.

DISCUSSION

Dr. French: I would like to nominate Dr. Saxton to draw up a strong resolution against pernicious use of the X-ray for cure of cosmetic defects.

Dr. Wilson: Resolutions won't help. I think a law should be passed in the state prohibiting the use of the X-ray by anyone not a physician.

Dr. Saxton: A resolution on this subject, while in order, will be of no effect. The efforts of the medical profession to get a law on such a subject passed, is "love's labor lost" on account of the ignorance, suspicion and apathy of the public.

Dr. Kirby-Smith: I would suggest that our secretary report these two cases to the Journal of the American Medical Association, as showing the results of tricho system. I wonder how many more, how many hundreds are afflicted by this treatment.

Case No. 7.—PITYRIASIS ROSEA. (Presented by Dr. C. A. Andrews)

Miss V. L., white, age 32, clerk. Patient first seen August 20, 1931. She stated that in June she had quinine injections for supposed malarial infection, bringing on a headache.

Distribution: On trunk, arms and thighs.

Description of dermatosis: On August 20, 1931, there was a generalized macular eruption, dark stained as if undergoing resolution. Laboratory findings: Two Wassermanns were negative. Treatment and results: The patient has had three X-ray treatments (¼ units) and an ointment consisting 2½ per cent salicylic and naftalan. The patient has not cleared up as rapidly as I think she should, and she is worried concerning her condition because of cosmetic appearance.

DISCUSSION

Dr. French: I should investigate this case, from the standpoint of a toxic rash. In addition to a food idiosyncrasy, investigate the pelvic condition following the lead of a left lower hypogastric pain. Dr. Saxton: The lesions in this case consist of discrete papules, with a more or less erythematous base, or halo. They are in all degrees of development from beginning to healing, or healed, leaving slight pigmentation. The newer ones have the top scratched off, and the skin shows dermographism. Whatever dermatosis she may have had, six weeks ago, I feel satisfied that this is papular urticaria.

Dr. Wilson: This case is at present a plain case of papular urticaria. I have not seen one before in an adult, but this does not alter my diagnosis.

Dr. Kirby-Smith: I agree on present diagnosis as papular urticaria.

Case No. 8.—Granuloma Inguinale. (Presented by Dr. J. J. Saxton)

R. L. C., colored, age 20, laundress. Lesion began as small sore at side of clitoris, three years ago. Has gradually spread around labia majora and into vagina. Had six doses of 606, one year ago, with little effect on lesions. At times had conjunctivitis, which cleared under 606. This is a service case at city hospital, but patient left hospital rather than submit to biopsy. There is also a palm-size lesion on left thigh anterior.

Description of dermatosis: An ulcer surrounds the vulva at the outer margin of the labia majora, also surrounds clitoris, extends into vagina, and around rectum. This ulcer is red and very little cecrotic. It has not the induration of granuloma inguinale.

Laboratory findings: Biopsy refused. Wassermann negative.

DISCUSSION

Dr. French: I believe the patient has syphilitic lymphederma.

Dr. Wilson: She has granuloma inguinale, but I believe, in spite of the negative Wassermann, that the induration is luetic.

Dr. Kirby-Smith: Agree with diagnosis and suggest treatment for syphilis. In seeing this case I can't recall having had in my office, in twenty-one years of practice, a case of inguinale granuloma. Should I have this patient, in private practice, under a general anesthetic, I would thoroughly destroy the ulcerations with diathermy.

Dr. Andrews: I saw this case a year ago with Dr. Saxton, and also later with a surgeon, but the patient has refused treatment. There has been surprisingly little change in the lesions.

Dr. Saxton (closing): The diagnostic thought, in this case, is syphilis, granuloma inguinale, ulcus vuulva acutum (chronicus). If cooperation of

the patient could be secured this condition could be diagnosed positively, or by exclusion, and doubtlessly cured.

CASE No. 16.—TRICHOPHYTOSIS. (Presented by Dr. C. A. Andrews)

E. P. A., white, age 41, theatre manager. Patient first seen on November 25, 1930. Laboratory findings: Spore infection was found under the microscope. Treatment and results: Various ointments, and X-ray were used, and the patient is apparently well, until it re-occurs. The patient feels that this is the result of army service, and is at the present time trying to establish fact for compensation. Duration of dermatosis: A number of years, at times so severely as to incapacitate him from business. Distribution: Between toes of both feet, and scattered areas, face, back, both elbows, left knee and scrotum.

DISCUSSION

Dr. Andrews: This case is just another one of the many that we all see in our offices. At the present time, the condition is giving him very little trouble. At times the lesions are distributed in scattered areas over the face, backs of elbows and knees, scrotum, and always has a well-defined trichophyton infection of the feet. I do not believe that any of us will disagree with the diagnosis. The treatment, in my mind, is a problem that we must still attempt to solve.

Dr. French: I agree with Dr. Andrews in all he says.

Dr. Saxton: Agree with Dr. Andrews. Dr. Wilson: I agree with Dr. Andrews.

Dr. Kirby-Smith: First of all the diagnosis is not in question, it is tinea. Both ankles show results of too much X-ray. Allow me to suggest for the cure of this patient, and others of the same trouble, use detailed treatment of the feet during the winter time. I have for my own practice, printed treatment instructions for this trouble. All indications are of tinea of the feet and nails, and unless you cure this you will not get anywhere

with the treatment of other regions.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912,

of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., published monthly at Jacksonville, Florida, for October 1, 1931.

STATE OF FLORIDA, { ss. COUNTY OF DUVAL. }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Shaler Richardson, M.D., who, having been duly sworn according to law, deposes and says that he is the editor of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of Publisher, Florida Medical Association, Inc. Post office address, Box 81, Jacksonville, Fla.

Editor, Shaler Richardson, M.D. Post office address, Box 81, Jacksonville, Fla. $\,$

Managing Editor. None.

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- 2. That the owner is: (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Florida Medical Association, Inc. (A Corporation not for profit—no stockholders).
- 3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.
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 5. That the average number of copies of each issue of this
- 5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only.)

FLORIDA MEDICAL ASSOCIATION, INC., By Shaler Richardson, Editor.

Sworn to and subscribed before me this 2d day of October, 1931.

(SEAL) NotaryPublic State of Florida at Large.
(My commission expires April 9, 1932.)

Form 3526—Ed. 1924.

NOTE.—This statement must be made in duplicate and both copies delivered by the publisher to the postmaster, who shall send one copy to the Third Assistant Postmaster General (Division of Classification), Washington, D. C., and retain the other in the files of the post office. The publisher must publish a copy of this statement in the second issue printed next after its filing.

THE NEXT MEETING OF THE FLORIDA MEDICAL ASSOCIATION WILL BE HELD AT SARASOTA MAY 3-4, 1932

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NOMENCLATURE AND CLASSIFI- CATION OF GOITER

The American Association for the Study of Goiter in seeking to simplify the nomenclature and classification of this disease takes a step in the right direction, one that deserves the commendation and support of the entire profession.

The fact that the division worked out by the Association is based upon two principles which are conspicuous for their exactness makes this classification not only easy to remember but altogether instructive. On the one hand, the group-

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ing deals entirely with the question of the physical aspects of the goiter; while, on the other hand, it is based on the presence or absence of constitutional intoxication. This arrangement calls upon the diagnostician only to arrive at an intelligent estimate of the contour and feeling of the gland and then establish the presence or absence of toxenia before being able to place the goiter into its proper class. Everyone realizes that the ability to segregate a disease into a group is of manifest advantage to a diagnostician in his study of any individual case. The simpler and more intelligent the line of division, the more it furthers the ease of diagnosis. The plan adopted by the Association creates these four types:

Type 1. Non-toxic Diffuse Goiter.

Type 2. Toxic Diffuse Goiter.

Type 3. Non-toxic Nodular Goiter.

Type 4. Toxic Nodular Goiter.

The Association has put its stamp of disapproval upon the use of proper names in the matter of nomenclature. Certainly all doctors should be glad of the opportunity to stand solidly behind that recommendation. The inclination to attach a man's name to a disease or a special symptom, just as is done in the case of a brand of chewing gum or other article of commerce, is deplorable. If that objection is not sufficient to discard its use, then, the fact that such practice forces the doctor to commit to memory a word that is meaningless gives additional reason against its usage. There is nothing in such a custom to aid the student in his work as is the case when some word recalls the anatomy, physiology, or pathology of the subject. It is easy to understand how terms which rivet one's attention to some peculiarity about a goiter are desirable. The minute one hears or sees such words as exophthalmic, hemorrhagic, congenital, etc., it conveys to them some special thing about the goiter in question which sets it apart from other goiters belonging to the same type.

It becomes necessary, then, under this analysis, only to remember not to confuse varieties or sequelae with types. On the one hand, it should be no trouble to remember that such terms as those just enumerated cannot possibly fulfill the demand of supplying constant characteristics about goiters in general and therefore they must apply to varieties only. On the other hand, whether a goiter is diffuse or nodular, can be applied to all goiters; similarly the matter of whether a goiter causes a systemic poisoning or not can be disposed of by

the same principle. Surely the American Association for the Study of Goiter should experience little difficulty in having the profession adopt a classification like this which combines the dual principle of simplicity and accuracy.

ACTIVITIES OF AN IMPOSTOR

The attention of the members of the Association is called to the fact that an impostor has been making the rounds of cities in Florida, calling upon doctors and obtaining money under false pretenses.

This man is about forty years old, is 5 feet 9 inches tall and weighs 160 pounds. He wears glasses, has blue eyes and a ruddy complexion. On October 20th, while in DeLand, he was dressed in a dark suit, gray hat and tan shoes and at that time he wore a Shrine pin.

In Key West he represented himself to be Dr. T. H. Bates of Lake City; in DeLand and Tallahassee he posed as Dr. James M. Acker, Jr., of Aberdeen, Mississippi. We know that he has operated in at least six cities: Daytona Beach, DeLand, Key West, Lake City, Orlando and Tallahassee. He is a good talker and has succeeded in securing loans from various doctors as well as getting bad checks cashed.

Any information regarding the activities of such men should be sent promptly to the Business Manager by wire collect so that we may, if possible, be able to apprehend them.

ANNUAL PUBLIC HEALTH CONFER-ENCE, JACKSONVILLE, DECEMBER 7-10, 1931

The meeting of the Florida Public Health Association promises to be one of the important scientific gatherings of the year. An unusual array of talent of national and international reputation has been secured. City governments will have an opportunity to detail their health workers to hear how the work is done in other places. One of the difficulties experienced by the individual in a more or less isolated community is lack of opportunity for consultations on problems met in the course of the daily routine.

The State Conference has arranged a program which provides a paper or address on each phase of state and municipal health activities. The meeting will occupy four days. Each morning is taken up with a general program of addresses by prominent guest speakers. The afternoons will be used for sectional meetings and round table

discussions on local, municipal and state problems.

The leading features of the first day are the opening address by our Governor on "The State in Public Health", to be followed by Dr. John A. Ferrell, Director of the Health Activities of the Rockefeller Foundation in the United States and president-elect of the American Public Health Association, with an address on "Education and Training of Public Health Personnel." Dr. T. F. Murphy, chief statistician for vital statistics of the U. S. Bureau of the Census, will tell of registration affairs and vital statistics.

Monday afternoon will be devoted to epidemiology and public health nursing.

Monday evening will afford an opportunity to serious-minded sanitarians "to shake a leg" and demonstrate that they are as young as they feel at a reception and dance from 9:00 p. m. to 12:30 a, m.

On Tuesday, the president of the Florida Medical Association, the State Health Officer of Alabama, the Commissioner of Health of Virginia, J. R. McCord of Emory University and one of Jacksonville's heart experts will deliver addresses showing the interrelationship of the medical practice and health work.

Tuesday afternoon promises to be interesting in featuring a child hygiene program with Dr. LeRoy A. Wilkes of the American Child Health Association as the principal speaker. A nationally known authority on public health nursing will address the Conference on the functions of a public health nurse in a state program. There will be schools and sessions for sanitary inspectors, details of which are not complete at time of this writing.

Wednesday morning will have as one of the leading features of the Conference a malaria symposium by Dr. Mark F. Boyd of the Rockefeller Foundation, Director of the Malaria Research Division of the State Board of Health, and Drs. L. L. Williams and T. H. D. Griffitts, of the U. S. Public Health Service. These are three leading authorities on malaria control.

On Wednesday afternoon, the Association of City Milk Inspectors opens a session which continues on Thursday as a milk inspectors' school with Mr. Leslie C. Frank, of the U. S. Public Health Service, and Mr. Ernest Kelly, of the Bureau of Dairy Industry, as the principal speakers.

Doctors interested will be furnished programs on request and are cordially invited to attend.

STATE NEWS ITEMS

Florida physicians, who recently attended the Clinical Congress of the American College of Surgeons included J. C. Davis, Quincy; H. C. Dozier, Ocala; Frank Gray, Orlando; N. M. Heggie, Jacksonville; C. J. Heinberg, Pensacola; B. W. Lowry, Tampa; Robert B. McIver, Jacksonville; Kenneth Morris, Jacksonville; M. A. Nickle, Clearwater; Shaler Richardson, Jacksonville, and H. E. White, St. Augustine.

* * *

Dr. Don S. Fraser of Panama City and Miss Margaret Van Cleve of Lynn Haven, Florida, were united in marriage October 8th. Dr. and Mrs. Fraser have recently returned from an extended motor trip through South Florida.

* * *

There will be a meeting of the Scientific Program Committee at the San Juan Hotel, Orlando, Saturday evening, 6:30, November 28th. Dr. O. O. Feaster, St. Petersburg, chairman of this committee, is planning to notify those who are to present papers at our annual meeting in Sarasota as quickly as possible in order that ample time may be given for careful preparation. If you are desirous of a place on the program, and have not already made application, wire Dr. Feaster, Power and Light Building, St. Petersburg.

* * *

Dr. J. Knox Simpson of Jacksonville will attend the meeting of the Southern Surgical Association in White Sulphur Springs, West Virginia, December 10, 11 and 12.

* * *

Dr. F. Peter Herman of West Palm Beach and Miss Lucille S. Williams were married in West Palm Beach on September 25, 1931.

* * *

Dr. J. D. Stuart of Miami is now located at 227 N. E. 5th Street. Dr. Stuart was formerly located at 127 N. E. 5th Street.

* * *

The new Saint Anthony's Hospital, St. Petersburg, with Mother Mary Magdalena in charge, opened the first part of November. This hospital has a bed capacity of approximately seventy.

* * *

Dr. and Mrs. J. R. Boulware, Jr., Lakeland, announce the arrival of James Richmond Boul-

ware 111, born October 2nd at Morrell Memorial Hospital. His great grandfather was Dr. James Richmond Boulware, a surgeon in the Confederate Army.

* * *

Dr. and Mrs. Max Ghertler, Miami, have returned to their Shenandoah home after quite an extended visit to New York.

* * *

Dr. Jack Halton, Sarasota, was recently appointed associate editor of American Medicine and International Journal of Surgery.

* * *

Dr. Franklyn Thorpe, formerly of Tampa and a member of the Florida Medical Association until 1930 when he moved to Los Angeles, was married to Mary Astor, screen star, June 29, 1931.

* * *

Dr. J. H. Fellows of Pensacola has just returned from a trip to the Middle West. Dr. Fellows attended clinics in St. Louis during his absence.

* * *

Dr. Harry Dash Johnson, 350 S. Palmetto Avenue, Daytona Beach, has returned from Bretton Woods, N. H., and will resume his practice this winter.

* * *

Born to Dr. and Mrs. Paul K. Jenkins of Miami Beach, a baby girl, September 29th, at the Jackson Memorial Hospital.

* * *

Dr. C. B. Wilson, Dr. J. E. Harris, and Dr. Joe Halton, of Sarasota, have just returned from vacations and post-graduate courses in New York.

* * *

Dr. Leigh F. Robinson of Ft. Lauderdale was recently elected to associate fellowship in the American Proctologic Society.

* * *

The ladies of the Auxiliary gave a bridge party in honor of the Volusia County Medical Society on October 27th.

* * *

Dr. James F. Curry of Dunnellon and Miss Neva Williams were united in marriage at Inverness, Florida, on August 1, 1931.

* * *

Dr. E. Clay Shaw of Miami has returned from a three months' sojourn abroad. He visited the various urological clinics in Great Britain, Norway, Sweden, Holland, France, Germany and Italy.

* * *

Dr. W. C. Page, Cocoa, spent considerable time this summer in post-graduate work at the New York Polyclinic Hospital.

* * *

The quarterly meeting of the Second District Medical Society was held at the Florida State Hospital, Chattahoochee, Thursday, October 8th, at 3 p. m. Dr. W. W. Massey of Quincy, vicepresident, presided in the absence of Dr. J. F. Williams, president. Dr. Mark F. Boyd read a paper on "Some Observations on Induced Malaria." This paper was discussed by Drs. J. G. Gainey and W. W. Massey of Quincy. Dr. J. C. Robertson, Chattahoochee, read a paper on "Treatment of Diabetic Coma." Dr. M. C. Wilensky, Chattahoochee, read a paper on "Glaucoma." This paper was discussed by Drs. H. M. Moore of Thomasville, Georgia, and O. G. Kendrick of Tallahassee. Dr. J. G. Gainey of Quincy read a paper on "Malignant Malaria a Causative Factor in Hematura in the Newborn with Report of Cases"; discussion by Dr. M. F. Boyd and others. Dr. B. A. Wilkinson of Tallahassee read a paper on "Scleroderma." At the business meeting which followed, Dr. W. W. Massey, Quincy, was elected president; Dr. B. A. Wilkinson, Tallahassee, vice-president; Dr. O. G. Kendrick, Tallahassee, secretary-treasurer; scientific program committee, Drs. W. W. Massey, J. H. Pound and O. G. Kendrick. Following the business meeting, a chicken fry and dance for the benefit of doctors, their wives and guests took place and a very pleasant evening was enjoyed.

* * *

Dr. and Mrs. Julian Leo Hargrove of Bartow announce the birth of a daughter, Dorothy Waldo, on August 8th at the Polk County Hospital.

* * *

Dr. Sheldon Stringer has resigned the superintendency of the Tampa Municipal Hospital, his resignation effective November 1, 1931. Dr. Stringer will devote his entire time to re-establishing his practice.

* * *

Announcement has just been received that applications must be on file with the United States Civil Service Commission at Washington, D. C., not later than December 30, 1931, for United States Civil Service examinations for Senior Medical Officer, \$4,600 a year; Medical Officer,

\$3,800 a year; and Associate Medical Officer, \$3,200 a year. If interested, refer to Bulletin No. 170 (Unassembled).

* * *

Dr. R. E. Repass is now located at 835 Lincoln Road, Miami Beach. Dr. Repass was formerly located at 337 Lincoln Road. His practice is limited to ear, throat and sinus diseases.

* * *

A very interesting meeting of the Orange County Medical Society was held the evening of October 21st at the Orange General Hospital. Dr. William Ross of Jacksonville read a paper on "Milk, with Special Reference to the Value of Certified Milk to the Individual and a Certified Dairy to a Community." Dr. J. H. Chiles of the Orange County Medical Society read a paper on "Infantile Impetigo Contagiosa." The Society voted to give an examination to all the students in the Junior High Schools to note defects and a cup will be awarded to the school which has the greatest percentage of these defects corrected at the end of the year.

* * *

Born to Dr. and Mrs. Leland H. Dame of Inverness a baby girl on October 3, 1931.

* * *

Dr. B. W. Lowry, Tampa, Dr. Kenneth Morris, Jacksonville, and Dr. C. J. Heinberg, Pensacola, were recently elected into the American College of Surgeons at their convocation in New York.

* * *

Dr. Nelson M. Black has returned to Miami after six weeks spent in Milwaukee, Wisconsin, during which time he attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology at French Lick, Indiana.

* * *

The Pinellas County Medical Society at its regular meeting October 15th had the pleasure of an address, "Crime and Its Relation to the Medical Profession", by Dr. Carlton Simon, criminologist of New York City.

* * *

Dr. Rosalie Slaughter Morton of Winter Park recently returned from a vacation spent in New York.

* * *

Dr. Y. C. Lott of Miami returned recently from a trip north, having done post-graduate work at the New York Polyclinic Hospital.

* * *

Dr. Nicholas P. Myers announces the removal

of his office to Bradenton, Florida. Dr. Myers was formerly located in Dowling Park.

* * *

The Central Florida Medical Society held its semi-annual meeting at the Highlands Club House, Ocala, Florida, Thursday, October 15. Dr. E. G. Lindner of Ocala, president of the Marion County Medical Society, gave the address of welcome. Dr. Gaston H. Edwards, Orlando, president of the Florida Medical Association, read a paper on "The County Society." Dr. J. Ralston Wells, Daytona Beach, secretary of the Public Relations Committee of the State Association, read a paper on "The Public Relations Committee's Activities." A twenty-minute period for discussion was allowed following each paper. The meeting was well attended.

* * *

Drs. John E. Boyd and E. T. Sellers of Jacksonville and Dr. A. F. Higgins of Tampa were guests of honor at the Volusia County Medical Society's first fall dinner meeting, October 13th. Dr. Boyd and Dr. Sellers led a discussion on "Medical Ethics." The meeting was in charge of Dr. R. L. Miller of Daytona Beach, president of the Society, Dr. J. E. Taylor, DeLand, vice-president, and Dr. J. Ralston Wells, Daytona Beach, secretary-treasurer.

* * *

Dr. M. A. Lischkoff of Pensacola recently returned after a pleasant vacation which included the meeting of the American Academy of Ophthalmology and Otolaryngology in French Lick, Indiana.

* * *

The first radio broadcast of the association over station WRUF was given on October 14th by Dr. Edward Jelks of Jacksonville. His subject was "Some Interesting Medical History in Florida." The music which interspersed the broadcast was furnished by Mrs. Theo. Croft of Jacksonville. The broadcast went over very satisfactorily and was well received all over the state.

Dr. and Mrs. D. A. McKinnon of Marianna recently entertained Mrs. Ed Ingram and little son of Jonesboro, Tennessee, as house guests.

* * *

Dr. and Mrs. Walter T. Hotchkiss returned to Miami Beach early in October after spending the summer visiting the Cleveland Clinic, Ann Arbor Clinics and the Mayo Clinic. They also attended the annual meeting of the American Academy of Ophthalmology and Otolaryngology at French Lick, Indiana.

* * *

Dr. H. E. Palmer of Tallahassee, dean of the medical profession in that city and a member of the State Board of Health, celebrated his 39th anniversary as a practicing physician of Tallahassee recently and was host to a number of local physicians and friends at a dinner in his home.

* * *

A regular meeting of the Polk County Medical Society was held Wednesday evening, October 14th, at the City Hospital, Bartow. Dr. Kenneth Phillips of Miami read a paper on "The Essential Nature of Bronchial Asthma." The society met as guests of the hospital and of Dr. C. J. Hurlburt, the superintendent. Dr. G. H. Edwards, president of the state association, delivered an address on "Cooperation of Individuals and of County Societies as a Means of Benefit to Them and to the State Association." Other guests of the society were Dr. W. H. Spiers of Orlando, Dr. E. B. Maxwell of Miami, and Dr. J. W. Alsobrook of Plant City. The meeting was unusually interesting and the attendance above the average. The visiting guests added to the good fellowship which was enjoyed by all present.

* * *

Dr. and Mrs. Cayetano Panettiere have returned to Miami Beach from spending part of the summer in Baltimore. They also attended the Interstate Post-Graduate Medical Association of North America at Milwaukee, Wisconsin.

* * *

Dr. E. A. Carter of DeLand was recently appointed county physician of Volusia County, succeeding Dr. J. E. Taylor.

* * *

The Brevard Hospital Association, incorporated not for profit, has acquired the Melbourne Hospital of Melbourne from Dr. I. M. Hay, and will operate same as Brevard Hospital; Dr. Hay to remain as surgeon in charge.

* * *

The second broadcast over WRUF was given November 11 by Dr. T. Z. Cason of Jacksonville, whose subject was "The Florida Medical Association: What It Is and the Value of Its Influence to the State." Miss Susan O'Hara, who recently won the Atwater Kent competition for the Jacksonville district, was heard in a series of musical numbers which preceded the medical discourse.

Dr. W. C. Payne of Pensacola has just returned from a trip to Atlanta, where he attended several clinics.

* * :

The following officers were elected at a recent meeting of the Pinellas County Medical Society: Dr. O. O. Feaster, president; Dr. L. M. Gable, 1st vice president; Dr. W. G. Post, Jr., 2nd vice president; Dr. Alvin L. Mills, secretary; Dr. George E. Miller, treasurer. The meeting night was changed from every other Friday to every other Thursday; the meetings to be held in the Assembly Room on the fifth floor of the Power and Light Building.

* * *

The Sixteenth Annual Clinical Session of the American College of Physicians will be held in San Francisco, California, April 4-8, 1932. The headquarters in San Francisco will be the Palace Hotel, where the general scientific sessions, registration, and exhibits will be held. Clinics will be conducted in various hospitals and institutions in San Francisco and nearby communities. Dr. S. Marx White, Minneapolis, president of the college, has in charge the selection of speakers and subjects on the general program, while Dr. William J. Kerr, San Francisco, professor of medicine at the University of California Medical School, is the general chairman of the session, and is responsible for all local arrangements, in addition to the arrangement of programs and demonstrations. Following the San Francisco session, a post-convention tour will be conducted through Yosemite Valley, Southern California (with two days in Los Angeles), and the Grand Canyon of Arizona.

* * *

Dr. R. E. Wilhoyte, Lake Wales, was away during the summer and did post-graduate work at the New York Polyclinic Hospital.

* * *

Applications for position of principal physiological chemist must be on file with the United States Civil Service Commission at Washington, D. C., not later than December 1, 1931. The examination is to fill a vacancy in the Bureau of Construction and Repair, Navy Yard, Washington, D. C., and vacancies occurring elsewhere. The entrance salaries range from \$5,600 to \$6,400 a year. Competitors will not be required to report for examination at any place, but will be rated on their education, training and experience.

Dr. and Mrs. Joseph H. Lucinian of Miami have returned from the North after a six weeks' absence. Dr. Lucinian spent several weeks at the Mayo Clinic X-ray department. Later he attended the American Roentgen Ray Society meeting in Atlantic City.

* * *

Dr. and Mrs. A. M. C. Jobson of Tampa recently returned from Mexico City, Mexico, where Dr. Jobson presented a paper to the Pan-American Clinical Congress and visited some of the clinics.

The Public Relations Committee held a business meeting at Gainesville, Thursday, October 8th. Those present were as follows:

George Dame	.Inverness
H. C. Dozier	
G. H. Edwards	
Ralph GreeneJa	
Henry Hanson	
John S. Helms, Sr	
J. M. Irwin St.	
Edward Jelks	
Ernest Milam	
Shaler Richardson	
J. A. Simmons	
H. Mason Smith	
W. H. Spiers	Orrando
W. C. Thomas	Gainesville
Stewart Thompson Ja	cksonville
G. C. Tillman	

Dr. Ralph N. Greene of Jacksonville was recently elected president of the Aero Medical Association of the United States at a convention held in Kansas City. Dr. Greene for many years has been intensely interested in aeronautics and holds a transport pilot's license. He is local representative of the National Aeronautical Association.

On Friday evening, October 2d, at 8:00 p. m., the Duval County Medical Society held an informal smoker at the Mayflower Hotel, Jacksonville. Dr. Robert A. Strong, professor of pediatrics, Tulane University, was the guest of honor, his subject being "Our Newer Knowledge of Nutrition." Dr. Strong also presented a series of talking, moving pictures, the subject of which was "The Preparation of Infant's Foods." Following the scientific program, a buffet supper was served. About one hundred fifty members and guests were present.

WANTED: Location or partnership in Florida town, 5,000 or over, by man aged 40. Five years' Florida experience. Have \$3,000.00 worth of equipment, modern X-ray. Do general practice and surgery. Address P. O. Box 301, St. Marys, West Virginia.

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Associate Professor of Clinical Psychiatry Georgetown University,
Washington, D. C.



ANALYSIS

Comparative Analysis of S. M. A. and Breast Milk

Chemical and Physical Analysis	S M. A.	Breast Milk
Fot	3.5-3 6%	3 59
Protein	13-1.4%	1.23-1.5
Carbahydrate	73.75%	7 57
Ash	0 25-0.30%	0 215-0.226
рН	68-70	6 97
Δ	0.56-0.61	0.56
Electrical Conductivity	0.0022-0.0024	0.0023
Specific Gravity	1.032	1.032
Coloric Value		
per 100 c. c , , , ,	680	68.0
per ounce	200	20.0

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WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

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Mrs. Edward Jelks,

2244 St. Johns Avenue Jacksonville

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According to present indications, the Florida Auxiliary will be well represented at the S. M. A. Convention, which meets in New Orleans November 18-20. Among those expecting to attend are: Mrs. S. E. Driskell, of Jacksonville, state president; Mrs. J. Ralston Wells, of Daytona Beach, past president; Mrs. L. F. Robinson, of Ft. Lauderdale, president-elect; and the following from Jacksonville: Mrs. E. W. Veal, president of the Duval County Auxiliary; Mrs. Luther Holloway, Mrs. Neil Alford, Mrs. H. D. Van Schaick, Mrs. Edward Jelks.

DUVAL COUNTY

The Woman's Auxiliary to the Duval County Medical Society held its annual meeting Wednesday afternoon at the home of Mrs. L. V. Tyler, in South Jacksonville.

The president, Mrs. William W. Kirk, presided. Activities of the past year were reviewed and officers for the coming year elected. Mrs. E. W. Veal was chosen president, with the following board: Mrs. Henry Hanson, vice president: Mrs. Chas. L. Jennings, secretary, and Mrs. S. R. Norris, treasurer.

It was decided to entertain the Duval County Medical Society at the close of their annual meeting.

Dr. Ralph N. Greene gave an interesting talk, after which a social hour was enjoyed.

HERE

is one of the advertisements of The Sugar Institute

THE advertisement reproduced here is one of the series appearing in newspapers throughout the country. In order to keep the statements in accord with modern medical practice, they have been submitted to and approved by some of the leading authorities in the field of human nutrition in the United States. The Sugar Institute, 129 Front Street, New York.

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In cooking meat, the combination of sugar and salt blends tastefully with the meat juices.

EVERY day your meat dealer offers cheap cuts of meat which have an irresistible appeal to your sense of thrift. And you can give most of these cuts an irresistible taste appeal by seasoning them with sugar.

Of course salt should be added to the meat as it cooks, to overcome flatness. But the value of adding sugar is that it develops and heightens the flavor of the meat in a

way no other ingredient can.
Try a dash of sugar to season pot-roasts, braised lamb
and yeal, stews and meat loaf.
In boiling corned beef or ham,
add a half cup of sugar, more
or less, to the water. "A dash
of sugar to a pinch of salt" is
also a fine seasoning for many
fresh or canned vegetables.
Flavor and season with sugar.
The Sugar Institute.

#Flavor and season with Sugar"



THE BOY WHO FOUND RAINBOWS IN COALTAR

One Easter vacation in 1856, 17year-old William Henry Perkin, a student-assistant in the Royal College of Chemistry, was toiling in an improvised laboratory under the eaves of his English home.

"Throw the rubbish away!" croaked unimaginative Common Sense, when the boy poured in a red fluid and got a dirty, sticky, dark mass at the bottom of his test tube. "Examine it!" whispered Science. "It may be worth something!"

Science was right. Out of that ugly dark mud came a lovely violet-purple dye. This "Mauve" was the first aniline dye ever made from coal-tar.

But young Perkin did more than found an industry. His experiments, and the experiments of other men in those early days, showed the way to a new, creative chemistry.

Men began to build with



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PARKE-DAVIS research chemists often spend years in producing a single synthetic chemical compound. For example, in a recent search for a synthetic drug to accomplish a certain purpose, hundreds of compounds were patiently built up. Each in turn was put to the severest tests. Finally one was obtained that met our exacting requirements.

Such is the spirit of the Parke-Davis laboratories. Steadfastly adhering to the high ideals that are woven into the fabric of the organization, stubbornly refusing to compromise with quality, the loyal men and women of our staff feel a keen personal pride in the confidence that the medical and pharmaceutical professions so willingly repose in the products which bear the Parke-Davis label.

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Volusia County

The Volusia County Auxiliary met for the first time this fall, on Tuesday, October 13, in Daytona, at Spiro's Grill. After a delightful dinner here, the members adjourned to the home of Mrs. J. Ralston Wells, where a most interesting meeting was held. Reports of the Auxiliary A. M. A. meeting in Philadelphia were given by Mrs. Wells and Mrs. Rutter. It was decided to give the members of the Volusia County Medical Society two parties this year instead of one. (Evidently no depression in Volusia!) The first of these parties was given on October 26th, at the home of the president, Mrs. L. V. L. Brown of DeLand.

The historian of the Florida Auxiliary, Mrs. J. M. Irwin, of St. Augustine, has compiled an excellent Scrap Book, which the Florida Auxiliary will be most proud to exhibit at the S. M. A. meeting.

These items were sent us by Mrs. Milton P. Overholser, of Harrisonville, Missouri, chairman of press and publicity for the Auxiliary to the A. M. A.:

"Our national president-elect, Mrs. Walter Jackson Freeman, of Philadelphia, went to Europe the first of August, expecting to return the first of September, but has been detained indefinitely by the illness of her son, who is laid up in Munich with an attack of inflammatory rheumatism. However, Mrs. Freeman is taking care of her department in the Bulletin of the American Medical Association.

Every physician who receives the Journal of the American Medical Association also receives the monthly Bulletin, which carries the national Auxiliary news. If we cannot train our husbands to bring home this Bulletin, we might subscribe for it ourselves, since it will be sent to any address for 50 cents per year.

Our national president, Mrs. A. B. McGlothan, attended the annual meeting of the Auxiliary to the Kentucky State Medical Society, Lexington, Ky., Sept. 7-10. She reports many interesting features of that Auxiliary. Each month from four broadcasting stations, a ten-minute health talk is given. Various physicians of the State Medical Association are selected to give these talks. This Auxiliary promoted a contest, carried on in ten counties, in which a prize was given to the school boy or girl writing the best essay on the value of a County Health Unit.

If your Auxiliary is not informed of the nature and value of the County Health Unit, devote



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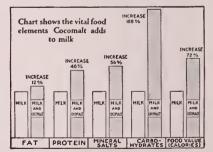
EXPECTANT MOTHERS—During pregnancy, Cocomait answers the great need for Vitamin D and helps provide the additional food needed by the developing foetus.

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Cocomalt—the delicious food drink—adds 70% to the caloric value of milk,

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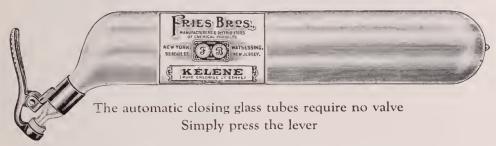
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See Description, Journal A. M. A. Volume XLVII, Page 1488

A scientific combination of Bismuth Subcarbonate and Hydrate suspended in water.
Each fluidrachm contains 2½ grains of the combined salts in an extremely fine state of subdivision.
Medicinal Properties: Gastric Sedative, Antiseptic, Mild Astringent and Antacid.
Indications: In Gastro-Intestinal Diseases, Diarrhoea, Dysentery, Cholera-Infantum, etc. Also suitable for external use in cases of ulcers, etc.

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Post graduate instruction offered in all branches of medicine. Courses leading to a higher degree have also been instituted.

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XCESSIVE perspiration does not search out its victims by sex. Men just as often suffer from its discomforts as women. This is especially true of hyperidrosis of the axillae, hands and feet.

The physical discomfort and social implication of excessive perspiration are equally distressing to men and women.

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checks the perspiration and prevents the odor, too. It needs to be applied only once or twice a week to those parts of the body not exposed to adequate ventilation. Trial supply gladly sent to physicians on request.

YES, I'd like to try NONSPI. Please send me a free trial supply.

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a meeting to the use of the Study Program on that subject, supplied by the national Auxiliary.

It is worth knowing that the American Medical Association will supply five-minute radio talks on seventy-two different health topics, and fifteenminute radio talks on sixty-two different health topics.

The Woman's Auxiliary Department, in the Florida State Journal, has given its readers recently, in two consecutive months, interesting reports of the Philadelphia Convention. One dealt with the convention at work and the other with the convention at play. Such reports help to create an interest in the Auxiliary as an organization with national significance."

ADVERTISERS' NOTES

RECIPE FOR COOKING MEAD'S CEREAL

When cooked according to the following recipe, and served with milk, Mead's Cereal is eagerly accepted by infants:

Place 2 rounded tablespoons Mead's Cereal and 1 cup cold water in upper section of double boiler, mixing with fork or wire whip. Place over direct flame for 10 minutes, while stirring. Replace upper section over lower section of double boiler and continue cooking for ½ hour the night before, and ½ hour before serving stirring occasionally, or, leave double boiler over "pilot" gaslight until morning. This makes a day's supply for the average infant. Number of tablespoons fed is increased from 2 tablespoons, according to age.

For older children, the consistency may be increased by using ½ cup of Mead's Cereal and 2 cups water (2 to 3 portions). Served with cream and sugar, Mead's Cereal deliciously supplies the growing child with protein, fat, carbohydrate, calories and, what is more important—calcium, phosphorus, iron, copper and other essential minerals.

Histories of medicine are replete with romantic accounts of weird beliefs that appear ridiculous in the light of our present knowledge. When Darwin's *Origin of Species* appeared, in 1859, the scientific men of that day were still having controversies on the origin of life. Such men as Pasteur and Koch laid the foundation for many of the brilliant researches that followed their day. The nineteenth century saw many improvements in surgical practice, thanks to anesthesia, antiseptics, and asepsis. Morton demonstrated ether anesthesia in 1846. Ether continues to be a boon to humanity, its benefits more recently improved through the use of sodium iso-amyl ethyl barbiturate, a product of the research division of the Lilly Laboratories, known as Pulvules Sodium Amytal. Sodium Amytal exerts a hypnotic, sed-

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As the name implies the features of a hotel and of a sanitarium are here combined.

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ative, and anticonvulsant effect. In surgery its preanesthetic use calms fear and apprehension, allows a quicker induction of inhalation anesthesia, lessens the amount needed, diminishes postoperative nausea and vomiting, and when used in conjunction with local anesthetics protects against potential toxicity of the latter,

Pulvules Sodium Amytal have been found of distinct use in obstetrics. Their administration materially shortens the time ordinarily required for complete dilatation of the cervix. The product is also said to have a number of uses in general practice; the correction of insomnia, the production of mental and physical rest in miscellaneous conditions, the control of convulsions, and, in conjunction with morphine, the relief of pain.

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Ten years ago this month the S. M. A. Corporation, then The Laboratory Products Company, announced an epoch-making development, S. M. A., to the medical profession. It represented a new idea, namely that cow's milk could be modified to resemble breast milk so closely that about 95% of the infants deprived of breast milk would do well on it, and that the anti-rachitic factor, cod liver oil, could be included so that no other protection would be necessary. S. M. A. is still the only anti-rachitic infant food available.

The idea for this adaptation had been conceived back in 1910, now twenty-one years ago. Clinical tests began in 1913. A preliminary report made to The American Pediatric Society in 1915, and a more extensive and elaborate one in 1918 before the Section on Diseases of Children of the American Medical Association, proved that S. M. A. was a marked advance in infant feeding.

The results obtained from feeding S. M. A. were so remarkable that practicing physicians asked for it. Eventually such a demand developed that S. M. A. was offered to the medical profession generally. It is estimated that to date more than three hundred million feedings have been prescribed by physicians, all over the United States and in several foreign countries.

The first infants to be fed S. M. A. are now school children and these, together with hundreds of thousands of others, are living examples of the soundness of the nutritional principles of S. M. A. in its first decade of service.

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THE NEXT MEETING
OF THE
FLORIDA MEDICAL
ASSOCIATION
WILL BE HELD AT
SARASOTA
MAY 3-4, 1932.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

	EDULE OF WELTINGS					
COUNTY SOCIETY	SECRETARY	Date	Time	ETINGS	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gamesville.	2nd Tuesday	12:00 Noon	White House	Yes.	77%
Bay	D. M. Adains, M.D., Panaina City.					100%
Brevard	1. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		90%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Com- merce	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		83%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally.	81%
DeSoto-Hardee- Highlands	Sebring.		8:00 P.M.	Varies	Yes.	100%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	88%
Escambia	J. M. Hoffman, M.D., Pensacola.	1st Tuesday	8:00 P.M.	Board of Health Building	No.	84%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	8+%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	83%
Madison	Geo. O. Davis, M.D., Madison.					68%
Manatee	A. Q. English, M.D., Manatee.	Oct. to May; 2nd Tues. May to Oct.	7:00 P.M .	Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	77%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	2nd Monday	8:00 P.M.	Court House	Yes.	88%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies .	Yes.	100%
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thursday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D.; Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.		Lakeland	Yes.	96%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. John's	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	- 100%
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies .	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
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WINTER SALAD (Six Servings)

Grams	Prot.	Fat	Carb.	Cal.
2 teaspoons Knox Spar-				
kling Gelatine 4.5	4			
1/4 cup cold water				
½ cup hot water				
½ teaspoon salt				
¼ cup vinegar				
1½ cups grated cheese150	43	54		
½ cup chopped stuffed				
olives	1	19	8	
½ cup chopped celery 60	1		2	
14 cup chopped green				
pepper 25			1	
1/3 cup cream, whipped . 75	2	30	2	
Total	51	103	13	1183
One serving	8.5	17	2	197

Soak gelatine in cold water. Bring hot water and salt to boil and dissolve gelatine in it. Add vinegar and set aside to chill. When nearly set, beat until frothy, fold in cheese, olives, celery, pepper and whipped cream. Turn into molds and chill until firm. Unmold on lettuce leaf and serve.

SPANISH CREAM (Six Servings)

Grams	s Prot.	Fat	Carb.	Cal.
1 tablespoon Knox Spar-				
kling Gelatine 7	6			
14 cup cold water				
1 cup milk	7	10	12	
34 cup boiling water				
2 eggs	13	10.5		
1½ teaspoons vanilla		10.5		• •
		• •		• •
Few grains salt				
Total	26	20.5	12	336.5
One serving	4	3	2	56

Soak gelatine in cold water five minutes. Heat water and milk over boiling water, add gelatine and stir until dissolved. Separate eggs and beat yolks until lemon colored. Stir gelatine mixture slowly into egg yolks. Return to stove and cook over boiling water until mixture begins to thicken. Remove from stove, add vanilla and salt and chill. Beat egg whites until stiff and fold into jelly when almost set. Mold and chill until firm.

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Relative Values of Carbohydrates

New Findings Confirm Old Truths

Recent scientific investigations in rats (tabulated at the right) are in accord with many years of clinical observations on babies, as shown by the following excerpts from authoritative medical literature reflecting the consensus of three decades of pediatric experience.

CHART OF CARBOHY	DRATE HYDROLYSIS3			
MILK SUGAR GROUP Lactose**	MALT SUGAR GROUP Starch			
(Milk Sugar)	Amylodextrin***			
Dextrose* Galactose*	Erythro- dextrin*** Achro- dextrin***			
	Maltose**			
CANE SUGAR GROUP Saccharose** (Cane Sugar) Dextrose* Leveloge	Dextrose* Nort The end product of matose is all dextrose which means quicker assimilation than end products from other carbohydrates.			
7/1/				
*Monosaccharide **Disccharide ***Polysaccharide Of the monosaccharide, dextrose, the end product of maltose, is converted into glycogen more easily than levulose or galactose. Therefore, maltose, which splits into two molecules of dextrose, may be absorbed with much less digestive energy than either lactose or saccharose.				

3 Morse, J. L. & Talbot, F. B. Boston Med. & Surg. Jl., 159:852.

RELATIVE ASSIMILATION VALUES OF VARIOUS CARBOHYDRATES' 1 MALTOSE.... 2 DEXTRIN + MALTOSE.... 1.32 3 Glucose + dextrin..... 4 Glucose + sucrose..... 1.32 5 Glucose... 1.04 0.98 6 Sucrose + maltose. 7 Fructose + glucose... 0.98 8 Sucrose + dextrin 0.76 0.76 9 Sucrose __ 10 Fructose.... 0.5 11 Glucose + lact 0.26 12 Lactose ... 0.16 13 Galactose These authors have also stated: "Maltose, fructose, glucose, starch and dextrin lead in nutritive value, followed by galac-

¹ H. Ariyama and K. Takahasi: Biochem. Z., 216:269 (1929) and ² J. Agr. Chem. Soc., Japan 5; 674 (1929).

tose, mannose, arabinose, xylose, lactose, sucrose and glycogen. 2

MALTOSE OR LACTOSE IN INFANT FEEDING⁵

Answer—The superiority of one form of carbohydrate over another in artificial feeding of infants has been much discussed during recent years. It is generally accepted that cow's milk without modification is not a satisfactory infant food. So far as the carbohydrate is concerned, about one-fifth to one-eighth ounce per pound of infant's body weight is required daily. To supply this amount it is necessary to add carbohydrates in some form. Admitting that lactose is the sugar supplied in human milk, it does not follow that it is the sugar best tolerated in another medium, such as cow's milk. It is generally believed that lactose is more laxative than sucrose—that it must be fed with a certain abount of caution, as fermentative upsets are likely to follow if amounts approximating that found in human milk are fed. There is cause for disagreement among clinicians, as it is important to consider the other food elements; i.e., the amounts of fat and protein fed as well as the medium in which they are fed. For example, when lactic acid milk is used, more added carbohydrate seems to be tolerated than when sweet milk mixtures are fed. Sucrose has the advantage of being much cheaper and is always available. Evidence has not been presented that it should

not be used in infant feeding. With its general use in large infant welfare clinics where supervision is a matter of routine, there is less to be said against it as far as clinical results are concerned. The complaint that it is too sweet is not often encountered when the usual amounts are fed. The dextrin-maltose preparations possess certain advantages. When they are added to cow's milk mixtures, we have a combination of three forms of carbony drates. Jactose, dextrin and maltose, all having different reactions in the intestinal tract and different absorption rates. Because of the relatively slower conversion of dextrins to maltose and then to dextrose, fermentative more said less likely to develop. Those preparations confaining relatively more maltose are more laxative than those containing a higher percentage of dextrin (unless alkali salts such as potassium salts are added). It is common experience clinically that larger amounts of dextrin-maltose preparations may be fed as compared with the simple sugars. Obviously, when there is a lessened sugar tolerance such as occurs in many digestive disturbances, dextrin-maltose compounds may be used to advantage. Squeries and Minor Notes, J. A. M. A., 88:266.

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PROGRESS THROUGH RESEARCH

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Number 6

CHRONIC COMPRESSION STENOSIS OF THE DUODENUM*

With Report of a Case Presenting Unusual Features

JOHN S. HELMS, A.B., M.D., F.A.C.S., Tampa.

The condition is probably not so rare as has been heretofore supposed. There appears to have been, up to 1900, brief literature referring to the condition only vaguely, without definite conception as to its real nature.

History. Duval¹ tells us, although Wilkie² seems to disagree, that the condition was first described by Petit in his graduation thesis at the University of Paris in 1900. Robinson³ reported two patients in 1900. Finney⁴ wrote his experience in 1906 and in 1912 Bloodgood⁵ presented an epochal paper. This was followed by reports of the work of the Kellogs.⁶ The literature has grown gradually, until its volume is large. A splendid historical resume is contained in an article by Higgins.⁷

Anatomic Pathology. Chronic stenosis of the duodenum usually occurs at its third portion, in the midline, where the root of the mesentery compresses the intestine at that point. Compression

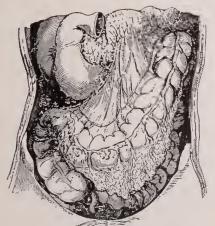


Fig. 1. From failure of agglutination of the ascending colon and hepatic flexure, the transverse mesocolon becomes attached nearly parallel with the mesentery in such manner that the right half of the third portion of the duodenum, genu inferius and second portion are supramesocolic.

by the superior mesenteric artery may be the chief factor, although compression by the colica media artery may play a secondary or, indeed, the chief role in some cases. This gives rise to two types of cases, as pointed out by Duval, the gastroduodenal type and the colonic type. This distinction is important, for each type needs a different type of duodenojejunostomy for its correction. In



Fig. 2. The transverse colon is raised; a bulging of the dilated third portion is seen between mesenteric pedicle and colica media.

the gastroduodenal type the transverse mesocolon is in a position of normal fixation, which is above the third portion of the duodenum crossing the second portion above the genu inferius duodeni. The compression in this type is caused by the superior mesenteric artery.

In the colonic type there is ptosis of the transverse colon and the hepatic flexure, and the agglutination of its mesentery occurs at varying degrees from its normal position to a position parallel to the direction of the root of the mesentery of the small intestine, bringing the colica media artery at varying degrees of approximation to the direction of the superior mesenteric artery. In this manner the colica media artery becomes the compressing agent. (Figs. 1 and 2.)

That portion of the duodenum which normally lies between the transverse mesocolon and the mesentery, or between the normal position of the colica media and the superior mesenteric artery,

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

is reduced to varying degrees by descension of the transverse mesocolon until it may be completely reduced, so that the genu inferius duodeni and the transverse portion of the duodenum lie above the mesocolon. This anatomic pathology must be taken into account in surgical technic. (Fig. 3.)

When compression stenosis of the third portion of the duodenum occurs from the superior mesenteric artery a great dilatation of the first and second portions of the duodenum above the mesocolon is observed. When the transverse colon is raised the genu inferius and the third portion are found to be dilated up to the root of the mesentery and the rest of the duodenum is normal in caliber or less.

In compression by the colica media artery the anatomic pathology is not so pronounced. There is less dilatation and the clinical symptoms are modified.

The stomach may or may not be dilated. Gastric distention may be very marked. Stavely⁸ and Wilkie⁹ have both reported cases with marked dilatation of the pylorus. It is believed that the gastric dilatation is secondary.

Marked congenital malformation may be present, such as faulty fixation of the colon or incomplete rotation of the intestine.

Pathogenesis. Duval¹⁰ states: "It seems that at the base of the mechanism producing compression by the preduodenal arteries there is always congenital malformation. Certain conditions acquired during life may increase the compression." Incomplete rotation of the colon and small intestines, with abnormal agglutination of the hepatic flexure and transverse mesocolon, are the chief factors of congenital origin in this mechanism.

There may be a short mesentery (Bloodgood), which may hold the small intestinal loops in sus-

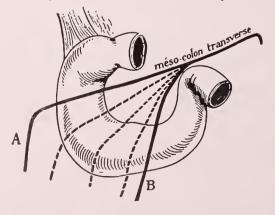


Fig. 3. Different locations of transverse mesocolon in oblique attachments.

pension without other support, thus compressing the third portion of the duodenum against the spine posteriorly.

An excessively long mesocolon at the hepatic flexure and the transverse colon (Kellog), with marked ptosis, may cause a closure of the angle between the superior mesenteric artery and aorta.

A relaxed abdominal wall, which may be congenital, or acquired, as in pregnancy, seems to be a secondary contributing factor which may cooperate with a short mesentery.

Longyear and Alglave and others have called attention to the congenital or acquired primitive renal ptosis supported in a secondary way by a coloptosis, bringing down the colica media artery and finally making traction upon the mesenteric artery, thus closing the angle between this artery and the aorta, compressing the duodenum at its third portion.

Congenital incomplete rotation, constituting marked volvulus, may cause compression at the third portion and at the jejunal first loop, as appears to have happened in the case reported herein.

Congenital malformations, therefore, play an important role in the pathogenesis of the condition of duodenal compression. After the primary condition of stenosis and dilatation of the duodenum have occurred infection may play a part in the production of adhesions to the gall-bladder and other adjacent structures. These adhesions may be secondary to preexistent congenital adhesions.

Other complications may be hemorrhagic pancreatitis, biliary infection and duodenal ulcer.

Hemorrhagic pancreatitis has been described by Wilkie. At autopsy he found great dilatation



Fig. 4. Saggital view of a human embryo 5 mm. in length.

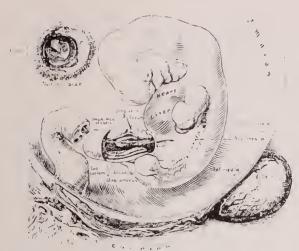


Fig. 5. Saggital view of the umbilical region in a human embryo 10 mm. in length.

of the duodenum. Duodenal stasis had favored penetration of septic material into the pancreatic duct and activated the pancreatic ferments.

"The sphincter of Oddi normally will prevent a reflux from the duodenum into the canal of Wirsung, but Oddi, in 1909, showed in 10 cases that the duct of Santorini becomes the chief route for the glandular secretion, and that, perhaps, this duct when abnormal is capable of preventing a duodenopancreatic reflux." (Duval)¹⁰.

These complications must be taken into consideration, for they call for certain modifications of treatment.

In order to understand the role played in this condition by congenital malformation, such as faulty rotation and faulty fixation of the mesentery and mesocolon, it is necessary to review the normal embryological processes concerned in these mechanisms.

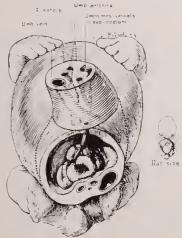


Fig. 6. Anterior view of the umbilical cord in a human embryo 18 mm. in length.

As has been pointed out by Cullen¹¹ and beautifully illustrated by Max Brödel, when the embryo is about 5 mm. in length the amnion is much larger than the yolk sack. The esophagus, stomach, liver and pancreatic buds and the first curve of the small intestine are clearly visible. These structures at this time are contained within the coelom. The cord now contains the omphalomesenteric duct and its vessels, surrounded by the exocoelom. (Fig. 4.)

When the embryo has reached 10 mm, in length, the small intestine still consists of one loop, but it has been drawn out into the cavity of the exocoelom contained within the cord. (Fig. 5.) As stated by Cullen, this is apparently due to traction by the omphalomesenteric duct and its vessels. There is beginning at this time what may be termed a physiologic herniation of the small intestine. By the time the embryo reaches the length of 18 mm.



Fig. 7. Saggital section of the umbilical region in a human embryo 23 mm. in length.

the small intestine shows many convolutions and nearly all the small bowel lies outside the body of the embryo in the exocoelomic cavity in the cord, while at a length of 23 mm. the exocoelomic cavity contains practically all the small intestine except the jejunum and all the colon except the descending. (Figs. 6 and 7.)

At this time the colon and the cecum lie to the left side and the small intestines lie to the right.

At a length of 4.5 cm, the intestines have receded entirely into the abdominal cavity. (Fig. 8.)

The causative factors, which determine the physiologic herniation of practically all of the midgut and finally its recession into the abdominal cavity, probably are not entirely understood. As Cullen¹¹ states, about the time the embryo is 10 mm. in length the small intestine which consists of one loop has been drawn out into the

exocoelom probably by the omphalomesenteric duct and vessels. The larger portion of the small intestine is then developed within the exocoelom.

The separation of the omphalomesenteric duct from the intestine seems to vary. "It has been found to be detached in a 7 mm. length embryo by Mall and in a 4.9 mm. embryo by Ingalls." ¹²

Ochsner, quoting from Dott,¹³ states in effect that the causative factors determining the physiologic herniation of the midgut are the rapid increase of the size of the liver and the rapid increase of the length of the intestine out of proportion to the rest of the abdomen.

Rotation of the midgut probably occurs simultaneously with its recession into the abdominal cavity. According to Frazier and Robins, this recession occurs between the fifth and tenth week. The exact cause of the recession of the midgut into the abdominal cavity appears not to be clearly understood. It appears, however, that the first stage of rotation begins in the exocoelomic cavity.



Fig. 8. Saggital section of the umbilical region in a human embryo 4.5 cm. in length.

Rotation probably takes place around the superior mesenteric artery as its axis. The duodenum passes underneath this artery, carrying with it the jejunum, the ileum following as the midgut is drawn into the peritoneal cavity. The cecum, being the largest and most distal unit of the midgut, is drawn through the umbilical opening and into the peritoneal cavity last of all. The cecum then normally drops to the right and descends to the lower right quadrant and normal agglutination of the ascending and transverse colon takes place. Posterior parietal fixation of the mesentery of the small intestine then occurs.

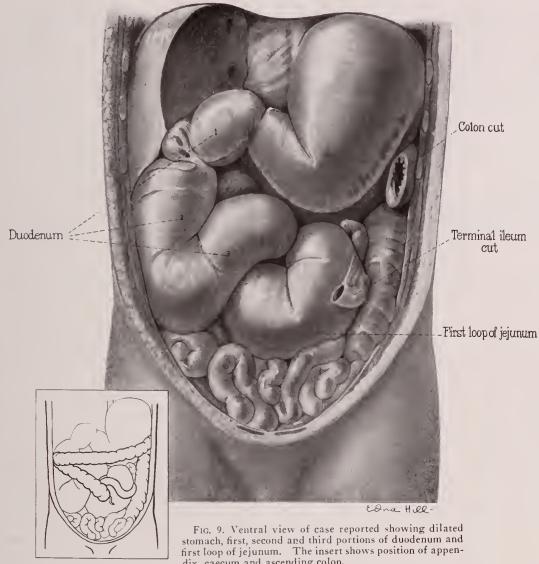
It can be readily seen that marked deviations from these normal embryologic mechanisms may cause serious consequences.

In the case reported herein it would appear that incomplete rotation of the small intestine occurred; in that only the distal part of the third portion of the duodenum and a segment of the first portion of the jejunum passed behind the root of the mesentery and the superior mesenteric artery, leaving the major portion of the jejunum to the right and the ileum in front and to the left of this artery in a postion of 180 degrees rotation, iliojejunal volvulus.

The cecum and ascending colon were incompletely rotated, the cecum having been arrested immediately underneath the umbilicus. The ascending colon was fixed in an oblique transverse curved direction from the cecum to the hepatic flexure, where it joined the transverse colon which was in its normal position of agglutination. A ventral view showed the ileum proceeding from the cecum in the midline toward the left in almost the position of the jejunum in the normal, except that it lay anterior to the superior mesenteric artery. On the other hand, the jejunum lay posteriorly to the superior mesenteric artery and proceeded immediately to the right, with its proximal segment compressed by the superior mesenteric artery about 3 cm. below the point of compression of the duodenum. (Fig. 9.)

The case presents a double chronic compression of the intestine by the superior mesenteric artery, first at the third portion of the duodenum and second at the first loop of the jejunum. Stenosis with enormous dilatation of first, second, proximal and terminal segment of the third portion of the duodenum and beginning of first loop of the jejunum and finally an enormous secondary dilatation of the stomach had occurred. (Fig. 10.) In addition to these findings, it may be stated that adhesive bands from the fundus of the gall-bladder passed over the duodenum between its first and second portion, causing a constriction at that point, which produced in the roentgenographic films four fluid levels. (Fig. 11.)

Diagnosis. Briefly the clinical diagnosis of this condition rests upon the presence of few but marked symptoms. The chronicity of the condition is marked. There is usually present pain in the epigastrium with epigastric fullness, particularly after meals. Nausea and vomiting after eating is an almost constant symptom. The vomitus may contain bile and pancreatic juice. Con-



dix, caecum and ascending colon.

stipation is nearly always present, though diarrhea of a duodenal type may occasionally occur. In the colonic cases the symptoms are not so marked and the condition not so severe as in the gastroduodenal type. Constipation is more marked in the colonic type. Emaciation and a muddy, sallow appearance of the skin is present in chronic cases. Headaches of the so-called migraine type are nearly always present in chronic cases. Nervous manifestations may be present.

The roentgenologic findings make certain the diagnosis, and treatment should not be advised without such examination.

Treatment. The treatment consists of medical and surgical measures. Medical treatment is only applicable to the mild type of cases and consists of posture, rest in bed, taking of quantities of fatforming foods and the application of properly fitting belts, pads and abdominal supports.

The knee-chest posture gives marked temporary relief. The mechanism is that the root of the mesentery in this position swings forward and upward, thereby relieving the pressure of the superior mesenteric artery upon the duodenum and the gastroduodenal contents pass into the lower intestine.

Surgical Treatment. In the gastroduodenal type, where the transverse colon is in its normal position of fixation and the stenosis is due to a chronic compression of the third portion of the duodenum by the superior mesenteric artery, a submesocolic duodenojejunostomy, the anastomosis between the first loop of the jejunum and the third portion of the duodenum being made to

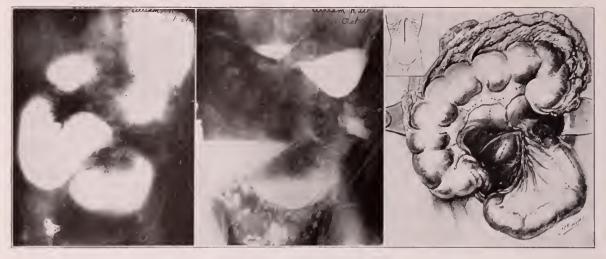


Fig. 10.—Roentgenographic film of patient showing dilatation of stomach, first, second and third portions of duodenum and first loop of jejunu.n—prone position.

Fig. 11.—Roentgenographic film of patient showing four fluid levels—standing position.

Fig. 12 (See also figs. 13, 14 and 15).—Progressive steps of technique in submesocolic and intramesocolic duodenojejunostomy.

the right of the superior mesenteric artery, gives complete and permanent relief. (Fig. 12.)

In the colonic type, that is, where there is a coloptosis of the right half of the transverse and the ascending colon, it is necessary to do an intramesocolic or supramesocolic duodenojejunostomy, making the anastomosis to the right of both the superior mesenteric artery and the colica media, which may become in this type of case the major factor in compression of the duodenum. It may be necessary to add in the colonic type a colofixation. In case a supramesocolic duodenojejunostomy is done, an added enteroenterostomy is called for. (Figs. 12, 13, 14, 15, 16, 17, 18 and 19.)

Case Report. On December 6, 1924, Mr. R. W. G., Jr., white male, aged thirty-five years,

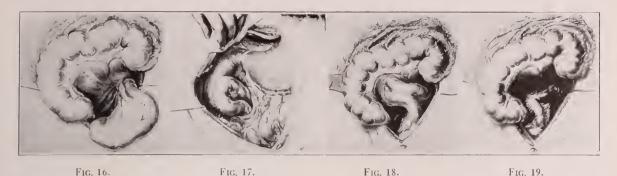
married, entered the clinic (Dr. E. W. Bitzer, internist), complaining of sour stomach, nausea, vomiting, nervousness and numbness in legs. Family history essentially unimportant.

Present illness began at the age of six years, at which time he had an attack of jaundice, which lasted several weeks. For several months following this he was fairly well, when he began to have sour stomach about two hours after meals. Nausea and vomiting occurred off and on up to the age of fourteen or fifteen years. This improved from this time on until an attack of dengue fever, two and a half years ago, when the same symptoms, sour stomach and indigestion, returned more severe than before. About two weeks ago the last attack occurred, which lasted three or four days, following which he began having blurring



Fig. 13. Fig. 14. Fig. 15.

Progressive steps of technique in submesocolic and intramesocolic duodenojejunostomy.



Progressive steps of technique in supramesocolic duodenojejunostomy.

of vision and numbness in the legs. His wife had observed a general weakness in the patient. He had lost about 20 pounds in the last two and a half years.

Roentgenologic examination refused and diagnosis was incomplete.

Re-examined by Dr. Bitzer for fullness and pain about umbilicus, particularly between meals, which has become more severe in the last six months. Has had three attacks lasting two days. Has lost 35 pounds in the last six weeks.

Physical examination showed an emaciated visceroptotic, sallow-complectioned individual.

Laboratory examinations were essentially negative, except for a moderately low red-cell count and a reduced hemoglobin.

Gastrointestinal X-ray series, Dr. J. C. Dickinson, shows obstruction at the duodenojejunal flexure, with enormous dilatation of the duodenum and stomach.

Operation. October 28, 1929. 180 degree ileojejunal volvulus was corrected. Adhesions from gall-bladder to duodenum separated. Adhesions about stenosis at first portion jejunum separated. Submesocolic duodenojejunostomy between second portion of the jejunum and third portion of the duodenum was done. Side-to-side anastomosis was made to right of superior mesenteric artery.

Final Diagnosis. Stenosis of the duodenum at third portion with stenosis at end of first loop of jejunum, due to compression by the superior mesenteric artery, with incomplete rotation of small intestines, cecum and ascending colon. Adhesions from gall-bladder fundus to first portion duodenum. Adhesions about stenosis of jejunum.

Patient discharged from hospital in good condition in fourteen days following operation.

Summary. There is presented a case of chronic dilatation of the duodenum and stomach and part of the first loop of the jejunum, due to the chronic

compression by the superior mesenteric artery at two points, viz., third portion of the duodenum and first loop of the jejunum.

- 2. The condition found in the case reported appears to have been caused by congenital abnormality connected with a faulty rotation of the midgut, evidenced by a position of the cecum immediately underneath the umbilicus, the ascending colon abnormally fixed in an oblique transverse curved direction up to the hepatic flexure and 180 degrees volvulus of the entire small intestine.
- 3. The small intestine was placed in a position of normal rotation, correcting the 180 degrees ileojejunal, volvulus. A submesocolic duodenojejunostomy to the right of the superior mesenteric artery was done.
- 4. The patient was immediately relieved of all clinical symptoms, gained 40 pounds in ten weeks, and remains well up to this time, more than one year following operation.

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Figures 4, 5, 6, 7 and 8 by permission; from "The Umbilicus and Its Diseases." by Cullen, published by W. B. Saunders & Co., Philadelphia.

DISCUSSION

Dr. J. C. Dickinson, Tampa:

It was my privilege to make the X-ray examination of this patient before operation.

When the fluoroscopic examination was begun two definite fluid levels could be seen, one in the cardiac end of the stomach, the other considerably lower and to the right just below the right costal arch. When the opaque meal was given it could be seen to float downward through a greatly dilated stomach and accumulate quickly in the greater curvature. By palpation it could be quite easily forced through the widely dilated pylorus, and it was then demonstrated that the second fluid level was located in the duodenal cap. The cap and duodenum were greatly dilated and the portion of the meal that had been forced through the pylorus formed a second level in the most dependent portion of the dilated first loop of the duodenum. By further palpation it was forced past a point of obstruction and a second dilated loop was demonstrated.

In a film made fifteen minutes after the examination was begun, three levels of the opaque meal could be demonstrated, one in the stomach and one in each of the dilated loops of the duodenum. At the end of six hours a large portion of the meal was retained in the stomach, as was also true at the end of twenty-four and forty-eight hours. At the forty-eighth hour observation the cecum and colon could be fairly well outlined, the cecum occupying a point above the umbilicus and to the left of the median line. The ascending colon passed to the right at the usual location of the hepatic flexure, the transverse colon again recrossing the abdomen in approximately normal position.

We have been permitted to re-examine this patient at four and six months after operation. The stomach is now contracted to practically normal size, there is no evidence of the markedly dilated stomach or duodenum and an opaque meal makes normal progress through the gastro-intestinal tract.

Dr. J. W. Snyder, Miami:

Dr. Helms has presented for our consideration a medical problem which, although discussed in medical literature for many years, is still surrounded by much uncertainty and almost mysticism. I have never personally recognized such a condition, but this may be entirely due to my inability to make the diagnosis. I am pleased to note the very conservative opinions expressed by Dr. Helms. The clinical picture as usually presented certainly does not warrant a ready diagnosis. The roentgenological findings are the most definite and from such real tangible findings of duodenal obstruction and dilatation alone may conclusions be drawn. The third portion of the duodenum is retroperitoneal and fixed, while over it passes the superior mesenteric artery which supplies blood to all of the small and most of the large bowel. If this mass of intestine is well supported by its mesentery with pads of abdominal fat and a strong abdominal wall, no tension should occur on the mesenteric artery, but if such support is inadequate then a downward pull on the artery may cause compression of the duodenum between the superior mesenteric artery and the aorta. Such a physical state occurs particularly in the asthenic, visceroptotic type of patient. Unfortunately, we all know the multitude of varied complaints these patients present, and how difficult it is to separate the real difficulty from the fancied. For this reason I would like to insist on the establishment of definite clinical evidence of obstruction before surgical measures are considered.

Therapy is both medical and surgical. Rest in bed with high caloric feedings, posture and exercise to tone up the abdominal musculature will relieve some cases. Bloodgood recommends resection of the right half of the colon to remove the drag of its weight from the mesenteric artery. The usual procedure, however, is a duodenal jejunal anastomosis. The procedure is not difficult and most reports give from a 50 to a 75% cure with the operation.

The attitude of most authors on the subject is quite evidently judicial rather than enthusiastic. We are fortunate that a man of Dr. Helm's ability and judgment has interested himself in this difficult problem.

Dr. J. S. Helms, Tampa (concluding):

The question of what to do always comes up in these cases, as in other problems, and it requires a considerable amount of judgment often to decide immediately what can be done in a given case.

Dr. Snyder spoke of Dr. Bloodgood's procedure of doing a colectomy. I think that Dr. Bloodgood, if he were faced with one of these cases at the present time, would not do a colectomy. While colectomy relieves the condition, yet at the same time he is doing a large operation that requires a large amount of resecting to relieve a condition that could be relieved by a much more simple operation. Of course, in the type of cases where the transverse colon is in the normal position of fixation and the hepatic flexure is also in the normal position of fixation, a submesocolic duodenojejunostomy takes care of the situation very nicely, and is a much more simple operation than some of the more formidable ones recommended.

In those cases where there is coloptosis as Dr. Bloodgood operated on, doing a colectomy, sometimes an intramesocolic duodenojejunostomy is necessary, and in some extreme cases a supraduodenojejunostomy as pictured in the slides would necessarily carry a loop of the jejunum through the transverse mesocolon and out through the side of the gastro-colic omentum making anastomosis in the second portion of the duodenum and then doing an entero-enterostomy. In this way the colon can be taken care of. That condition is expedited by doing a colon fixation by the method of Waugh. I think that is much more preferable than to do a colectomy, which is a dangerous operation.

STERILITY* FERDINAND RICHARDS, M.D., Jacksonville.

I know of no more fitting expression in speaking of sterility than to quote Graves, who states: "Sterility occupies a unique place in medicine but is somewhat difficult of precise scientific definition." Literally and briefly, it means a fruitless marriage. It is estimated by some authorities that about twelve per cent of all marriages are sterile, and that from twenty to forty per cent of these can be traced to the male, with the remaining sixty per cent to the female. For descriptive purposes there are three main types or classifications. The first is spoken of as absolute sterility, a condition wherein impregnation is impossible due to developmental defects. The second is spoken of as primary sterility, denoting that the individual,

apparently normal, does not conceive under normal conditions of married life, usually the first three to five years. The third class, or type, is spoken of as secondary or acquired sterility, denoting that type of individual who although at first capable of fertilization, later becomes incapable.

ETIOLOGY

First it is important to realize the ease with which conception takes place with the mating of a normal young virgin and male free of venereal disease, pregnancy almost invariably occurring immediately after such a mating. Time and space does not permit the writer to present all of the etiological factors found in this condition, but an effort will be made to discuss the most common causes which the physician encounters in the treatment of sterility. These causes may be divided broadly into two groups, idiopathic and acquired. The chief idiopathic causes of sterility are fetalism and infantilism of the genital organs, fetalism relating to faulty or arrested development occurring in intra-uterine life. Common examples are seen in women with such defects as bicornate uterus, septate vagina, absence of vagina, anomalies of the fallopian tubes and ovaries. In men, we find double epididymis, undescended testicles, a congenital stricture of the vas deferens, etc. Infantilism applies to those individuals born with a full equipment of genital organs but in which an arrest in development takes place during childhood. In these cases we see such conditions as infantile uterus, small hypoplastic ovaries or small hypoplastic undeveloped testicles. This type is more common in females than in males, and those individuals may appear normal and healthy but fertilization is obviously impossible.

Of the acquired causes of sterility gonorrhea is by far the most important, affecting both sexes. In the female the cervix, tubes and ovaries are the most common site. The so-called "one child sterility" is frequently the result of this infection as seen in pregnant women whose tubes become infected post-partum. The cause of sterility in men, outside of impotency, is commonly due to gonorrhea involving the epididymis with the globus major or minor the most frequent site of infection, the vas deferens, prostate and prostatic urethra. In women it is estimated that about thirty-three to thirty-five per cent of sterility is due to this infection, while in men the percentage is considerably higher and has been estimated to be as great as seventy per cent.

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

Puerperal sepsis is another acquired cause, which at the same time may result from gonorrhea. When the infection is entirely puerperal it is probable that less permanent damage is done. Usually the infection invades the pelvis through the lymph channels of the uterus and parametrium, attacking the tubes from the outside.

Endocervicitis, not gonorrheal in origin, is more readily susceptible of cure than are most of the other causes. Lacerations, leukorrhea, chronic hypertrophic changes and cystic degeneration manifested by painful intercourse, hypersecretion of the cervical glands and at times accompanied by formation of an abnormally dense mucus plug which mechanically obstructs the cervical canal may be, and frequently is, the cause of sterility. Pregnancy takes place at times in patients with a profuse muco-purulent vaginal discharge, but if the secretion is strongly acid it forms a medium in which it is impossible for the spermatozoa to survive.

Endometritis is rarely, if ever, the cause of sterility, with the possible exception of tuberculosis. Genital tuberculosis is nearly always attended with sterility.

Ovaries: Various pathological conditions of the ovaries may or may not be a factor in producing this condition. It has been fairly definitely established that simple cystic degeneration of the ovary is not a cause of sterility. The corpus luteum cyst has no bearing on this condition. Congested and enlarged ovaries resulting from displacement, such as prolapse, retroflexion, may be a cause of sterility, but these changes are usually secondary, while such conditions as ovarian hypoplasia, seen in infantilism, is a definite cause of sterility with practically no hope of relief. appearance, these ovaries are usually abnormally small, flat, or spindle-shaped, thick and of a dense whiteness due to a thickening of the tunica albuginea, or connective tissue cortex. Or they may be abnormally large due to follicle atresia resulting from failure of development beyond the primordial stage with an increase in the connective tissue elements; manifested clinically by late onset of menses, dysmenorrhea, oligomenorrhea, amenorrhea, failure of the sexual impulse, and vicarious menstruation. Metrorrhagia at times is also seen. It is possible that the internal pressure of the follicle may be deficient on account of incomplete congestion as seen by scanty or infrequent menstruation; also, it is not uncommon to find no trace of corpus luteum in these cases. Sampson demonstrated years ago the etiology of the chocolate cyst, and also established the fact that the great majority of women affected with this condition are sterile. The large multilocular cyst, dermoid cyst and fibromas of the ovary are known to be causes of sterility, and when occurring bilaterally there is a hopeless prognosis. We must not forget, however, that many patients presenting pictures of hypo-ovarianism, along with other endocrine disturbances, yield nicely at times to treatment properly applied, and pregnancy results.

Salpingitis: Women with a history of salpingitis are, in the majority of cases, sterile, or at least looked upon as sterile. In the light of conservative treatment with less surgery on the tubes, it is reasonable to believe that a better check on this condition will be available in the future with more encouraging results, especially in gonorrheal salpingitis, which is responsible for about eighty-five per cent of these cases. Tuberculosis claims about five per cent with mixed infections from the staphylococcus and streptococcus, causing perisalpingitis and peritonitis, the remaining ten per cent.

Misplacements: It is a well established fact that acquired misplacements of the uterus, such as retroversion and flexion, at times are causes of sterility, this being proven by pregnancy frequently following the restoration of the uterus to its normal position. Another important fact not to be overlooked is the position of the cervix in these cases. When placed high in the vagina and pointing upwards or parallel with it, conception is not likely to occur.

Tumors: Tumors, whether benign or malignant, may also play an important role in this condition in both male and female, by involving any part of the genital tract.

Miscellaneous causes: Debilitating diseases as seen in tuberculosis, syphilis, diabetes, the leukemias, etc., often cause sterility, the uterus undergoing atrophic changes as an end result. Frequently sterility accompanied by obesity is seen in endocrinopathies, such as hypothyroidism and acromeglia. It is also seen in Graves' disease, Addison's disease, and other pathological conditions of the endocrine glands. There is another form or type of sterility about which little is known, seen in women who become pregnant but usually abort in the early weeks of pregnancy. Several theories have been advanced as to its cause, and it is possibly due to developmental defects of the fetus or abnormalities of the reproductive germ cells.

DIAGNOSIS

The diagnosis in this condition is, as a rule, not difficult, but to find the cause is frequently difficult, and at times impossible. Complete cooperation of the husband and wife is absolutely essential. One is just as important as the other and unless this cooperation is assured it is impossible to render satisfactory and complete service to your patient. It is well to have a definite routine in these cases and the following is suggested:

A careful history which includes inquiry into the data already mentioned, with particular reference to marital relations, the menstrual history, abortions, etc., and a thorough general and local physical examination is essential. The woman is instructed to appear one or two hours after intercourse. Do not allow her to void until a specimen of vaginal and cervical secretion has been obtained for examination, to determine the number, motility and viability of the spermatozoa and also the reaction of the vaginal secretion. Sometimes a second post-coital specimen is needed after several days, and if the spermatozoa are absent, dead or sluggish, obtain a condom specimen. If this specimen is normal in number, activity and viability, it is reasonable to conclude that the trouble lies in the female, but if there are dead spermatozoa or aspirmia, or oligospermia, refer the husband to a competent urologist to determine his condition. Until he can be eliminated satisfactorily, it is useless to proceed with the wife.

Determination of tubal patency is invaluable. Tubal insufflation, peri-uterine insufflation, or the Ruben test, is one of the most important diagnostic and therapeutic aids in this field of work and cannot be too strongly advocated. The technique of this procedure is more or less familiar to all; also its contraindications. Occlusion of both tubes means sterility, but there may be only one tube closed or there may be but a partial occlusion, or they may open under pressure. This latter is very valuable as a therapeutic agent. The use of lipiodol injection in the uterus and tubes has a limited field of usefulness, chiefly in localizing the site of tubal obstructions, and possibly congenital anomalies. Aside from these, it has no advantage over insufflation which is less dangerous.

TREATMENT

Elimination of hopeless anomalies and end results of infection is essential. The correction of incorrect sexual relations, periods of continence of four to six weeks, sometimes helps. A valuable

time is within the middle two weeks between two periods, then if a period is missed, abstain from intercourse until a diagnosis of pregnancy can be made, because an impregnated ovum is easily blighted during the early stages of gestation. Improvement of the general physical condition, correction of diet, etc., are all important in the treatment. Elevation of the hips is extremely important in Effluvium Seminis. The use of alkaline douches is of some help in correcting acid secretions, but most particularly in removing mucus plugs from the cervix. Antiseptic douches should be absolutely avoided. The use of the electric cautery in endocervicitis is probably our best weapon in treating this condition. In patients with a low grade endocervicitis, a simple procedure and at times a very effectual one, is to first insufflate the tubes and if found open dilate the cervix, swab the uterus with tincture of iodine and complete the procedure with a cauterization of the cervix.

The use of the curet, except in diagnostic proccdures for obtaining specimens, has no place in this field of work. Pregnancy has been known to occur by simply dilating the cervix, swabbing the uterus with full strength tincture of iodine and having the patient have intercourse as soon as possible thereafter, within an hour or two. men anastomosis of an occluded vas deferens with a globus major of the epididymis has given good results at times, in the hands of competent urologists. Pessaries sometimes help in displacements by replacing the cervix and fundus of the uterus to its normal position, also by relieving pelvic congestion and pressure on the tubes which is sometimes a cause of obstruction. Postural changes, as the knee-chest position, may be of some help. Correction of functional ovarian disturbances sometimes occur spontaneously or may be benefited by fractional doses of X-ray. The use of thyroid extract in hypothyroidism is also beneficial, but should be governed by the basal metabolic rate. Surgical procedures, other than the ones outlined, offer very little encouragement and should be avoided when possible. The removal of small cystic ovaries has little or no advantage. Uterine suspensions are sometimes followed by pregnancy but the same results can usually be obtained with the use of the pessary. Many of these patients are high-strung, nervous individuals, and failure of pregnancy to occur after being subjected to major surgical procedures is shocking and hazardous. Artificial impregnation has been employed with good results but is seldom practiced.

PROGNOSIS

The prognosis should always be given carefully and guardedly. It is reasonable to expect pregnancy to occur when both individuals are highly fertile and normal. It is safe to believe that pregnancy will take place when one is low in the degree of fertility, but it must be realized that pregnancy will not occur when both individuals are low in fertility. Sexual incompatabilities occur at times, although both individuals appear normal. The cause is difficult to elicit and frequently after a careful study of cases with no apparent pathology, sterility still exists. However, at times the most simple remedy, together with careful advice and instructions from the physician, properly carried out, will reward your patient with a pregnancy.

CONCLUSION

In conclusion, the writer wishes to state that he takes no credit for originality of any of the methods of diagnosis or treatment, but has only a desire to stimulate interest in this field of work where much can be accomplished by a careful study of all patients presenting themselves as victims of this unfortunate condition.

DISCUSSION

Dr. J. M. Bryant, Jacksonville:

This is the first scientific paper that I have heard read in the State of Florida on the subject of sterility. There is not a great deal about it in the current literature. This is a very important subject, and it seems to me that a subject that is neglected in the literature is no doubt, to a great extent, neglected in daily practice. If Doctor Richards has succeeded in arousing your enthusiasm, particularly in regard to the multiplicity of the etiological factors involved in the majority of these cases, and also the importance of a full and systematic scientific investigation as to the causes of this condition and the institution of the proper treatment, then I think his paper alone is worth your time here. A home where there are no children, where children are desired, is certainly a very important situation. It is equally important to the physician when his services are solicited. Any one who has done a great deal of gynecology can probably recite many cases which will emphasize this importance. I wish to recite one case that will emphasize almost everything I have to say:

A young Army officer, about thirty years of age, had been happily married for about five years. Having no children, they sought the services of a physician, who was probably more surgically than gynecologically inclined, and he assumed, along with the husband, that the wife was 100 per cent at fault. Therefore, he advised and carried out an abdominal operation in which a salpingorrhaphy was done on both tubes." Several years later, sterility still persisting, when this case was more thoroughly investigated, it was elicited that no history, so far as the husband was concerned. and very little so far as the wife was concerned, was taken at the previous examination. A careful history of the husband revealed the fact that at some previous time he had had a gonorrheal epididymitis. He did not remember whether one side or both. Also he had had an orchitis following the mumps, but did not remember whether one side or both. Examination of the semen revealed only a very few spermatozoa, being curled up and deformed and very slightly active. In this case, as in many other sterile matings, the husband was very likely entirely at fault.

This goes to show you how important it is for the physician, whose advice is sought in conditions of sterility, to investigate the husband as well as the wife. In fact, he should be held equally responsible until he has been definitely proved innocent.

Doctor Richards has reviewed the literature very thoroughly and has covered all phases of recognized methods of treatment. There are just a few high spots I would like to mention.

One is that the husband should be referred to a competent urologist who is better equipped to carry out a thorough, systematic examination of the male. There may exist a urethritis, prostatitis, seminal vesiculitis, stricture of the urethra, and many other conditions that the urologist is more able to locate and better prepared to institute the necessary therapeutic measures.

As far as the wife is concerned, in practically 75 per cent of the sterile women, the condition is due to occluded tubes. Fortunately, we have the Ruben test, not only to discover occluded tubes, but to be used as a therapeutic measure. Also the majority of occluded tubes can be opened under the Ruben insufflation method, if carefully carried out. It may require two or three insufflations.

As for the diseased cervix, cauterization is very satisfactory. I do not mean the radical cauteriza-

tion as carried out for gonorrheal endocervicitis, but the very light linear cauterization that goes into the diseased mucosa only. A thin watery discharge has probably no bearing upon sterility and may be disregarded.

As far as the curette is concerned, it is my belief that there is very little, if any, benefit to be derived from the use of this instrument. Many of the bleeding disorders thought to be due to such diseases as chronic endometritis, metritis, fibrosis uteri, etc., are, in reality, expressions of some disturbance of unknown origin in the ovarian function. A curettage in cases of this kind is very much like applying a stream of water to a column of smoke when the location of the fire is unknown. It can accomplish nothing, and may do much harm.

A great deal can be said for and against roentgen therapy in cases of sterility when ovarian function is at fault. Personally, I believe it very difficult to indict specifically ovarian function as being primarily at fault. The ovaries are just a link in a chain of factors of which the thyroid and pituitary glands play a part. The proportionate effect of normal or abnormal function that these glands, separately or combined, have on sterility, is none too well understood. A person with very little active ovarian tissue may be permanently sterilized by the average dose of roentgen rays. It is reasonable to believe, however, that this method may have some value in carefully selected cases. Personally, I am not very enthusiastic in recommending its use.

I thank you.

Dr. H. R. Mills, Tampa:

I would like to offer one suggestion in regard to the laboratory determination of male fertility. The usual laboratory method is to ask for a warm condom specimen. However, in my experience I have found it an advantage to have the specimen ice cold. Now I always ask for ice cold specimens in making tests of this character. I have frequently found specimens of semen submitted warm without revealing motile spermatozoa after one hour, and the same specimen showed many actively motile spermatozoa after twelve hours in the refrigerator and a few showed motility after three days' refrigeration. The advantage of using a cold specimen is that it enables the laboratory to examine condom specimens several hours after they have been collected. The reason spermatozoa are apt to appear dead after a few hours in a warm specimen, is probably contamination as these specimens are almost always contaminated by bacteria, the growth of which refrigeration prevents.

Dr. W. M. Rowlett, Tampa:

I have enjoyed listening to Dr. Richard's splendid paper on sterility. I agree with him on practically every point, with a possible exception of his text-book quotation, that from twenty to forty per cent of the trouble is traceable to the male.

After years of study of the subject, with special attention to semen defects, I feel confident that he would be perfectly safe in doubling that per cent. While gonorrhea still remains the leading factor, the present day mode of living is a ground-gainer for race extermination. If I may suggest, the next time you have a barren couple that is desirous of children, where the venereal history is negative, the young wife as far as you can find is normal, her husband apparently healthy, but one of these early-to-work, inside men, with social ambition, where the microscopical examination of a condom specimen shows a mixed field of dead and faintly active spermatozoa, try changing his mode of living, to an early to bed, early to rise regime, plenty of fresh milk, eggs, fruit and vegetables, and golf about twice a week, with an occasional prostatic massage.

Relative to endocervicitis, I believe that seventy per cent of these cases are gonorrheal in origin. I likewise believe that a large number of men who have had gonorrhea never become entirely cured of the disease, contrary to the opinion of their physician, and that many of them become gonorrheal carriers. The only reason that such a man doesn't reinfect himself from his wife is that he has established an immunity to that particular strain.

Lipiodol roentgenograms are one of the greatest aids in locating the trouble in cases of sterility and furnish you with a clinical record that has no equal. To subject a wife to any operative procedure in order to correct a sterility, without first examining the husband, is malpractice.

There is one cause for sterility that Dr. Richards did not mention, and that is immunity that a woman may develop to a certain strain of spermatozoa. In fact, it has been contended that you can immunize a wife against her husband by giving her sterilized hypodermics of her husband's semen.

Again I wish to thank Dr. Richards for his splendid paper.

POLIOMYELITIS* H. Mason Smith, M.D., Tampa.

The increasing importance of poliomyelitis which has been demonstrated in the frequency of epidemics, the severity and widened scope of the recent epidemic, makes it a subject which should be looked into with greater concern by the medical profession in all parts of the country. It is on account of this fact that I am discussing the subject and not because I have any original thoughts as the results of my own work to offer.

While this disease is endemic the world over and we have a few cases in Florida throughout the year, the epidemics occur in the warm weather of cold climates. The recent epidemic, which is the second largest, has occasioned cases to occur in nearly all parts of the country due to contacts that were made in the area of the epidemic. We do not know when the virus of this disease may change its characteristics so that it may spread in epidemic proportions in the south.

ETIOLOGY

The experiments conducted by Flexner and Lewis, in which they succeeded in transmitting poliomyelitis from monkey to monkey, gave the opportunity for better study and search of the infecting organisms. These men found no growth after many trials. Many types and kinds of organisms have been cultivated from poliomyelitis tissue and spinal fluid of advanced cases, but no organisms are found, or have been found, in cultures made from tissues obtained in experimental cases in monkeys as soon as the monkey becomes prostrate, so the organisms in the cultures made from advanced cases are considered as secondary invaders.

There is one organism, the globoid bodies, that beyond a doubt has to do with the infection of poliomyelitis. The disease has been produced experimentally in the first twenty transplants of the globoid bodies, and the disease has been produced from these globoid bodies after thirteen months of latency; however, experiments intended to show the immunological relationship of the globoid bodies were negative. The opinion now held by Amoss and other men working with these organisms is that they afford the proper conditions, either mechanically or chemically, to absorb the organisms and nurture them. It has

been known, of course, that the organisms of this disease is a filterable virus, and is a classical example of the very small living things, or agents.

PATHOLOGY

The old concepts of an intoxication or an exclusive inflammatory process in the anterior horn cells was abandoned a few years ago. Poliomyelitis is a systemic disease and the virus invades all the tissues of the body. The nervous system is the last to be invaded. In the usual case when the nervous system is involved there is congestion, infiltration and edema of the arachnoid, and pia membranes of the cord, medulla, pons, cerebellum, and cerebrum. The dura is usually not involved. The blood vessels are congested, and their sheaths are infiltrated with round mononuclear cells, particularly in the lumbar and sacral regions.

This inflammatory reaction follows the vessels from the periphery to the interior of the cord. The vessels are dilated and engorged; the capillaries are enormously distended; the anterior horn being richer in blood supply, is therefore most affected, and besides the hyperemia and edema in the gray matter with distended capillaries, there are often hemorrhages of sufficient severity to cause a destruction of the cells, and a permanent paralysis follows. Of course, the cells, that is, the ganglion cells or motor cells, which are in the anterior horn, undergo varying degrees of degeneration, and among the completely degenerated cells may be found some normal cells, which accounts for the difference in the course of these cases.

The paralysis occurring as a result of the functional involvement, that is, the edema and hyperemia of the anterior horn, is usually far in excess of the permanent anatomical loss, hence, the remarkable recovery we see in some cases when this clears up.

The spinal nerves are involved also at their junction with the cord, in some cases extensively, causing the polyneuritic type of the disease. The disease always involves to some extent the upper part of the central nervous system, but when the main process is in the pons, we have that bulbar type of the disease, which has been so universally fatal.

EPIDEMIOLOGY

All ages of man are susceptible to this disease, the most common age being from two to nine years of age, but no animal except man and ape harbor the disease. The mortality varies ten to forty per cent, and is controlled largely by the

^{*}Read before the Third Annual Meeting of the Florida Public Health Association, Jacksonville, Dec. 7-10, 1931.

frequency of bulbar cases. The disease is endemic the world over, but epidemics occur in the colder climates during the late summer months. The disease is highly communicable, but selectively. In the worst epidemics the attack rate is computed by Amoss to be one to two hundred. Very few cases can be traced to a preceding case, but it is highly probable that carriers play a great role.

In the epidemic of 1916 in New York, contact was the immediate factor in 20 per cent of cases. In the Maryland epidemic of 1928, Aycock and Eaton concluded that many of the secondary cases in 253 families could be traced to the same source as the primary cases. In this epidemic there were two cases in three homes and three cases in one home.

The virus, or globoid bodies, have been found in the nasal washings of a thirteen-year-old girl sixteen days before the onset of the symptoms. Thus, communicability is far in advance of the symptoms. The duration of communicability is not fixed, but immune bodies appear in the blood three to four days after the onset of the symptoms, so the prodromal stage is more dangerous for communication of the disease than the acute stage. The period of incubation is from three to eighteen days, but the average is much less than eighteen days, usually eleven.

Flexner and Lewis, in producing experimental polionyelitis, packed the nares of a monkey with a pledget of cotton moistened with the virus in suspension. They determined that the disease was produced if the cotton remained in place overnight, but if the plug remained in the nares only two or three hours, the monkey remained well. However, in a monkey that had previously received intra-spinal injection of normal horse serum, the virus passes to the nervous system and provokes the disease. These experiments have been interpreted to suggest that there is a defense mechanism of the meninges, which is broken down by the protein reaction, or an aseptic inflammatory reaction incited by the horse serum.

They also decided that the first line of defense was in the capacity of the nasal secretions to neutralize the virus. This may be absent in acute or chronic rhinitis, when the disease is usually contracted. Aycock and Luther reported sixteen cases following recent tonsillectomy. In these cases the first line of defense was broken. Antiseptic solutions and washes also break down this barrier or defense, and it is said that during the epidemics the employment of nasal douches containing anti-

septics are not only of no value in preventing the disease, but actually render the person susceptible to it

IMMUNOLOGY

For a long time it has been known that the virus of poliomyelitis is neutralized by blood serum of people who have passed through an attack of the disease and monkeys who have had experimental poliomyelitis are immunized monkeys. It has been found also in people who have had suspected abortive attacks the serum would neutralize the virus and in many people who have not had any attack, serum has been attained which also neutralized the virus.

In order to work out the immunology of people who have not gone through with the disease Aycock obtained serum from 75 normal adults who gave no history of having passed through the disease; 46 were residents of cities, and 29 were residents of the country, in the most rural sections of Vermont and New Hampshire. In the urban individuals he found that in about 70 per cent the serum would neutralize the virus; in the rural it was a striking difference as only 6 cases or 20 per cent neutralized the virus while 80 per cent did not. It is estimated from this and other experiments that only one in ten is susceptible.

Aycock contends that immunization is obtained by exposure to virus; that with each exposure there is some virus entering into the system of the individual, not sufficient to produce the disease but probably enough to produce a subclinical attack, which causes immunity. Naturally, there are more exposures in the urban population. He also figures that the immunization of poliomyelitis follows that of diphtheria in ratio as to urban and rural communities. He has produced immunity in monkeys experimentally by injecting sub-cutaneously minute doses of the virus repeatedly.

This being the case there are many mild and unrecognized attacks of poliomyelitis where the individual himself does not know that he is suffering from any unusual condition. Naturally there are many people who get the virus in the naso-pharynx not sufficient to produce the disease, but probably sufficient to be a carrier and it is this otherwise healthy person who goes from place to place carrying the virus and scattering it among those highly susceptible.

Aycock gives as his idea of the reason that epidemics occur in the summer months of cold climates, that the seasonal changes are more pronounced in cold climates. Reid Hunt, as an authority on the physiological changes in the tissues during the seasonal changes, states that this lowers the resistance to infections. According to his explanation, in southern climates the disease does not come epidemically as the seasonal changes are more mild.

TREATMENT

The use of convalescent serum in the treatment of poliomyelitis first began in 1911 by Netter. Since that time it has been used by various workers in uncontrolled experiments. With all who used it both in treating the disease in the human, and experimental cases in the monkey, the results were obviously of value when given during the first forty-eight hours after the onset.

It was not until 1927 that any number of treated cases could be compared with a number of untreated cases in the same epidemic, which would serve as a controlled experiment. All cases in Massachusetts that year were under the supervision of the Harvard Infantile Paralysis Commission.

In 1183 untreated cases there were 165 deaths, giving a case fatality rate of 15.2 per cent, while in 106 treated case only one death occurred, giving a case fatality rate of 0.9 per cent. The muscular impairment was equally reduced in the surviving treated cases.

In 1928 Berry treated 101 cases with the serum in Maryland. Forty-nine were treated in the preparalytic stage. He summarized in the bulbar cases the fatalities as being 70 per cent in the untreated group and 10 per cent in the treated, and the residual paralysis as being less in the treated group.

The potency of the serum has never been standardized, and so far the dose has been decided arbitrarily by the amount of serum available.

In Quebec a smaller dose is being given than in Massachusetts, where 20 cc. is given intraspinously and 60 intravenously, which dose is possibly repeated the second day.

The serum is obtained from donors who have had a frank attack of the disease during the last fifteen years and who are otherwise healthy. As much blood as advisable is obtained from each donor under the most aseptic conditions. After separation it is tested by the prescribed federal requirements for contamination and pooled with other serum.

In Quebec a preservative of equal parts of 0.2 per cent solution of phenol is added and with this

preservative the potency of serum made in 1929 is still good. Experiments are being made at drying the serum, but so far nothing satisfactory has resulted.

Nowhere have I found any laboratory willing to dispose of any serum, so it is futile to endeavor to purchase any in case of a need.

In any discussion of the treatment of the infantile paralysis the Drinker Respirator deserves a conspicuous position. This is a machine that was invented by Dr. Philip Drinker and Louis Shaw of the Harvard School of Public Health at the suggestion of the Consolidated Gas Co., of New York, which was to be used for resuscitation of asphyxiated persons. It is a large metal box into which the person unable to breathe is placed all but his head. It is so constructed that with an electric pump and a rubber diaphragm, a vacuum can be created which is sufficient to pull up the chest, which action pulls air into the lungs. The vacuum is then released so that the air is exhaled. This interrupted vacuum causes respiration at a normal rate. It has been used in asphyxiation from all causes, especially carbon monoxide gas poisoning, alcoholic coma, drug poisoning, drowning, post-operative respiratory failures and asphyxiation of the new born. These machines are made in two sizes, suitable for adults and children.

During the recent epidemic in the north it was found to be of great value in treating the bulbar cases of infantile paralysis until the edema is cleared up in the gray matter of the bulb. Many patients have been tided over this period and their lives have been saved, which without the respirator would have yielded to respiratory failures. The mortality of bulbar cases has been reduced greatly by this apparatus.

Since an early diagnosis is so important in this disease as a matter of therapy I have reserved this until the last topic of this discussion.

DIAGNOSIS

The disease is so rare in this section and the initial symptoms are so mild that in most cases a physician is not called until the paralysis is seen. Therefore, the medical men see few cases in this stage, and may fail to diagnose them when seen. The time has come when the parents should be warned of the seriousness of what may appear to be a minor complaint, and for the medical profession to become familiar with the initial picture of this diabolical disease.

Aycock and Kramer of the Harvard Infantile Paralysis Commission have written on the preparalytic diagnosis and a quite constant initial symptom syndrome is described.

The first symptoms to appear are frontal headache of a persistent type, a gastrointestinal upset and mild fever, 101-104. While the gastrointestinal symptoms are fairly constant, they are not striking. There is some epigastric distress, nausea and usually vomiting once or twice; many children complain early of pain and stiffness in back of neck. In most cases, this is all the information that can be obtained. On physical examination the patient is found to be more markedly prostrated than the fever justifies, the face flushed, the child drowsy, but easily aroused, alert and apprehensive when disturbed. Sometimes a tremor, rather coarse in its nature, is observed. A well-marked "tache-cerebrale" is obtained. Throat injected, pulse rapid. The reflexes may be normal or hyperactive; Kernig and Babinski are usually absent.

The outstanding diagnostic findings are a stiff neck and stiffness of spine, brought out on an effort to flex head on chest or anterior flexion of trunk. It is noticed when the child attempts to sit up he does so by a series of shifts with his hands keeping neck and back stiff. The sitting position is usually not reached, the trunk remaining in a reclining position supported by hands, the position of head and trunk so straight that the term "poker spine" is applied.

The spinal fluid pressure is moderately increased and appears clear, but presents a ground glass appearance when placed against a dark background. Globulin is increased. The cells vary from 50 to 2000, but in the majority of cases are between 100 and 400. The type of cells have varied too much for this to be of any diagnostic value.

Polymorphonuclears may predominate early and later lymphocytes.

THE USE OF LOCAL ANESTHESIA IN THE TREATMENT OF FRACTURES* JAMES M. HOFFMAN, A.B., M.D.,

Pensacola.

The reduction of fractures is a problem that confronts practically every physician, be he situated in the rural districts, or in the larger centers of population. The subject that I wish to discuss is not new, but surely it is not being used as often as it could be used, both from the standpoint of the doctor and the patient.

In a general way, let me review the technic in general use. This procedure is surgical, and deserves the same respect, in the matter of asepsis, as any other surgical procedure. The skin of the affected region must be thoroughly cleansed and a suitable antiseptic applied. Any suitable local anesthetic solution may be used. Personally, I prefer 1% novocaine solution, for reasons that are not necessary to discuss at this time.

An ordinary 10 cc. Lucr type syringe is used with a needle of varying size, depending on the fracture site. The anesthetic solution is injected directly between the ends of the fractured bone in case of fracture, and within the joint space in the case of dislocations. It can be used in fractures or dislocations in practically any region of the body. Usually, it is necessary to use about 20 to 30 cc. of the novocaine solution to obtain anesthesia, which results in 10 to 15 minutes.

From the patient's standpoint, he is not subjected to the discomforts of a general anesthetic, post-anesthetic vomiting, confinement to bed, etc., and the fears of post-anesthetic complications.

From the doctor's viewpoint, it has numerous advantages over general anesthesia. First of all, you have the cooperation of the patient in placing the affected part in different positions, which would not be obtained if he were asleep.

When the pain is relieved, the muscles contiguous to the fracture relax, and manipulation is made easier. Fluoroscopic examination of the injury can be made without fear of explosion of the anesthetic from sparks.

The anesthesia lasts long enough that resettings can be accomplished until entirely satisfactory, without the fear of too prolonged general anesthesia. It can be used in the doctor's own office, without recourse to an anesthetist.

This procedure is particularly adaptable in children. When the pain is relieved, you have a thoroughly cooperative and interested patient.

This method can only be used in fractures less than twenty-four hours old, as after that time, the anesthesia is not complete and the muscles do not relax.

The only contraindication that I know of, is a compound fracture, as in these cases the anesthetic solution will escape through the skin wound.

I feel very much enthused over this method and use it in all cases of simple fractures or dislocations, even in those cases where I formerly used no anesthetic. The gratitude of your patients, and the results obtained, will more than compen-

^{*}Read before the Escambia County Medical Society, Pensacola, November 10, 1931.

sate for the added trouble of preparation and short wait for the local anesthetic to take effect.

I will present a few case reports to illustrate its use:

E. B., injured April 5th, 1931, in auto accident. Complete spinal transverse fracture of distal third of left tibia and complete spinal transverse fracture of proximal third of left fibula. The patient was suffering severe pain on the least movement. Thirty cc. of 1% novocaine solution was injected at the fracture site of the tibia. The fracture of the fibula was not noticed because of the apparent severe injury in the lower leg. In about ten minutes, he suffered no pain on manipulation of the fragments. Reduction was effected and a plaster cast applied. Radiographic check showed good end to end approximation of fragments of tibia, and the fracture of fibula was found. No further adjustments were necessary. An excellent anatomic and functional result was obtained (5899).

G. A., injured in an automobile accident April 7, 1931. Radiographic examination revealed a complete transverse fracture of the distal third of the tibia, with overlapping of fragments. About two inches above the site of fracture, there was a deep penetrating wound of the soft parts. Thirty cc. of 1% novocaine solution was injected between the bone fragments. In about fifteen minutes, reduction was effected without pain to the patient. A plaster cast was immediately applied with a window for dressing of injury to soft tissue above fracture. Radiographic check-up revealed good end to end apposition of bone fragments. An excellent anatomic and functional result was obtained. (Case No. 5902.)

W. B., aged 9 years. Complete transverse fracture of both bones of forearm at middle thirds with marked overlapping of fragments. Twenty cc. of 1% novocaine solution was injected at each of the fracture sites. Reduction was effected in about fifteen minutes and a splint applied. Radiographic check-up revealed an excellent reduction. The functional and anatomic result is excellent. (Case No. 5977).

J. B., aged 7 years, injured April 13, 1931. Complete transverse fracture distal third of left radius with external displacement of distal fragment and an incomplete transverse fracture of the distal third of ulna. The child had such severe pain that it was difficult even to examine his arm. Thirty cc. of 1% novocaine solution was injected at the fracture site of the radius. In a few minutes the child quieted and allowed us to effect a reduction. Manipulation of the fracture was made

under fluoroscopic observation. An excellent result was obtained. (Case No. 5926).

S. M., aged 8 years, injured October 20, 1931. Incomplete transverse fracture proximal third of ulna, with dislocation of head of radius at elbow. The dislocation was causing most of the pain. Thirty cc. of 1% novocaine solution was injected about the head of the radius. Reduction was effected after a short wait with full cooperation of the patient. The child is still under observation, but an excellent result is assured. (Case No. 7441).

DISCUSSION

Dr. W. C. Payne, Pensacola:

I agree entirely with Dr. Hoffman in his conclusions. I feel that the treatment for fractures is an important surgical procedure. Most doctors have occasion to treat fractures, and unfortunately not enough care is taken in their management. Physicians will often refer surgical cases to one more skilled than they in surgery, and yet will treat a fracture that should require more surgical judgment than the ordinary operation. Local anesthesia simplifies the treatment of fractures. Nerve block is more satisfactory in skilled hands, but infiltration between the ends of the bones is simpler.

Dr. C. M. Shaar, Pensacola:

Seventy-six fractures were treated last year and 110 the year before at the Naval Air Station, and but one general anesthetic was used. I find it better to block the nerves higher than site of fracture, rather than infiltration, particularly in the forearm. In the humerus, brachial block is preferable. In the lower extremity, skeletal traction is the accepted treatment with ice tongs or Steinman pins. Where traction is used, no anesthesia is necessary, other than for insertion of pins or tongs into the bone. In compound fractures, nerve block is the method of choice. There is no question of the value of local anesthesia in fracture work.

Dr. J. M. Hoffman, Pensacola (closing):

I wish to thank Dr. Payne and Dr. Shaar for the able discussion of this subject. My purpose in presenting this paper was to bring to your attention the simplicity of the infiltration method, and its practical, universal application. We all feel, that in skilled hands, nerve block is the method of choice, but the practitioner not skilled in this method, may find the use of infiltration anesthesia of great benefit, particularly if the facilities of a first-class hospital are not available.

SPINAL ANESTHESIA* CLAUDE ANDERSON, M.D., Tampa.

Perhaps the greatest advance in surgery in the past twenty-five years has been the development and widespread use of spinal anesthesia. It is now considered that this type of anesthesia is relatively safe and the complications incident to its use in the early years of its development have been rendered negligible, due to refinements in technique and to better and safer anesthetic materials.

It was my privilege to have the opportunity to work with the late Dr. John B. Deaver in Philadelphia in 1929 and 1930. He had long been an advocate of spinal anesthesia and had used it in several thousand patients with entire satisfaction. He continually demonstrated its advantages to the many thousands who flocked to his clinic, and he showed very clearly how superior to other forms of anesthesia it was, especially when used in patients with suppurative conditions of the abdomen. Perhaps no other surgeon in America has equaled the genius displayed by Deaver in his management of the "dirty" and "nasty" abdominal cases. He has stated many times that spinal anesthesia in such conditions is a big factor in rendering the operation easier and in saving the life of the patient. Practically all of the larger clinics in America have adopted spinal anesthesia as a part of their armamentarium. In many places in the North and East, it is used routinely in all operations below the diaphragm. In the South, and especially in Florida, it is not used as often as it deserves to be.

During the two years which I spent at the Deaver Clinic, I had the opportunity to give approximately four hundred spinal anesthesias, and during this time and while at the Lahey Clinic as a Fellow in surgery I saw approximately two thousand other patients so anesthetized. For the most part I assisted with the operations on these cases and had charge of the pre- and post-operative treatment. Consequently, I have had the opportunity to see the effects of spinal anesthesia on the operating table and during the convalescence of the patient.

In this large series of cases, there were no fatalities which could possibly be attributed to the anesthetic, nor were there any serious complications or sequelae.

No other anesthesia will permit the surgeon to

work with such ease, facility and precision in practically all operations below the diaphragm. Truly the conditions more nearly approach that which we find in the cadaver than with any other anesthetic at our command. Under such conditions the surgeon can do his best work. Any one who has had to tug and pull on retractors, and who has fought with distended coils of gut which continually pop up into the wound, even after the most expert and careful packing off, is astonished at the ease with which this is accomplished under sub-arachnoid block. All the tissues are relaxed, the intestines are contracted, respirations are easy and quiet and, as a general rule, the patients are quite comfortable. Maximum exposure can be obtained with the least injury to the tissues.

After the operation has been concluded, we have a patient who is awake, alert, able to converse with relatives and who, as a general rule, is in the best possible condition; or, if he has had narcotics, he is in a peaceful and refreshing sleep. He does not awake with retching, nausea, or vomiting. He is able to take fluids and food immediately as far as the anesthetic is concerned; and he is comparatively comfortable and complains little of incisional pain.

We do not now dread the complications and sequelae which so commonly followed the use of spinal anesthesia in the early years of its development—in fact, most of them have been eliminated. In Babcock's series of five thousand cases of spinal anesthesia, vomiting was far less common than with ether. Mild headache occurred in 21% of the spinal anesthesias and in 50% of the ether cases, being more severe in the latter. Backache only occurred in 16% of the cases in which spinal anesthesia was used in contrast with 61% of the ether cases. The average duration of post-operative incisional pain was 29 hours with spinal anesthesia whereas it was 48 hours when ether was used. No cases of albuminuria occurred in this series.

I recall seeing only one case of severe headache and this cleared up in five or six days in response to postural and eliminative treatment. We can safely say that now complications from spinal anesthesia, when the proper technique has been followed and we have selected our cases carefully, are negligible and should not occur.

It is difficult to compare the mortality rate of spinal anesthesia with that of ether. Our ether patients generally recover from its immediate effects, but they not uncommonly die of complications which may be due to its latent effects on

^{*}Read before Hillsboro County Medical Society, July 7, 1931.

the liver, kidneys or lungs. All of these are not attributed to the anesthesia used. When a spinal anesthetic death occurs, it is usually sudden, dramatic and directly attributed to the anesthetic. When a post-operative rupture of an incision occurs, which may be due to the retching and vomiting caused by ether, if death follows it is rarely said to be due to the anesthetic used.

Sise² has estimated that the death rate should be ideally placed as about one in eleven thousand, but that probably it is one in three thousand the country over, given as it is in some places to all types of patients, and by men who have not had adequate training and who do not understand its actions. Babcock3 has not had a death in the last 16,000 injections. Labot4 has had no death since 1916. Deaver reported two deaths due to the anesthetic in approximately 8,000 operative cases. Sise⁶ has had one or two deaths in the past two years. It is my opinion that a spinal anesthetic death should never occur. If we were perfect in our judgment in selecting our patients and in our technique we should never have a death which could possibly be caused by the anesthetic. But, we are not infallible and we shall probably continue to have deaths which will decrease in number as our experience increases.

It is a dangerous method of anesthesia when it is used indiscriminately, carelessly, and by one who does not exercise good judgment in the selection of his patients and who is not skillful in the technique. We should not reserve this type of anesthetic for only the moribund, the poor risk, the obese, the senile, the sclerotic patient—certainly not, unless we are most skillful in its use. To such patients only the most expert should attempt spinal anesthesia and then only when he feels that with its inherent dangers it is safer than any other anesthetic. While we are still inexperienced, let us use it only in the young or middle aged, healthy, robust individual. We can gradually widen its scope as our experience increases.

There are a few definite contraindications to spinal anesthesia and others less well defined and not generally appreciated; the failure to understand the latter may account for some of the accidents which occur.

In Dr. Deaver's clinic, spinal anesthesia was never refused a patient when the operation was of sufficient magnitude to warrant either that or a general anesthesia, except in cases in marked shock such as occur with traumatic rupture of the liver and some bullet wounds of the abdomen. The perforated ulcer patient and those with acute pancreatitis all seemed to do well under spinal anesthesia. Despite this wide use of spinal anesthesia there were only two deaths in a series of 8,000 cases, and all of these cases were anesthetized by internes and not by experts. The internes, however, had observed the work of the preceding interne for several weeks and had practiced lumbar puncture on cadavers. They were carefully supervised by Dr. Deaver at the beginning of their services. Our results there should be about what the average surgeon may expect from this anesthesia, but of course not so good as those obtained by such experts as Babcock, Sise, or Labot.

Number operation July, 1929,

to March, 1930	1196		
Number spinal anesthesias	643	54	%
Good take	552	85	%
Additional anesthesia	65		
Fair take	25	3.9	%
Additional anesthesia	22		
Poor take	66	11	%
Additional anesthesia	65		
Total number additional			
anesthesias	152	23.7	5%

This table illustrates the results that we obtained during the last nine months of my surgical service under the late Dr. Deaver⁵. I gave the anesthesia to about three hundred of these patients.

During the months from July, 1929, to March, 1930, there was a total of 1,196 operations; 643, or 54%, received spinal anesthesia. This was entirely satisfactory in about 75% of the patients; approximately 24% required additional anesthesia because of nervousness, poor relaxation, no anesthesia at all, or the desirability of having the patient insensible to the conversation or lecture regarding the operative findings.

At that time we were very conservative and used small dosage. Since then, at the Deaver Clinic, with changes in the technique and an increase in the dosage the results have been a great deal better, and now it is probable that only 10% of the patients require additional anesthesia. I believe that Sise at the Lahey Clinic used additional anesthesia in less than 3% of his cases. At this clinic it is probable that spinal anesthesia is used in at least 90% of operations below the diaphragm. However, it is rarely, if ever, given in very poor risks or in moribund cases. Usually we attempted operations on such cases with regional anesthesia. Recently, in the prolonged stomach

operations, we have used on a few cases avertin plus regional anesthesia, which has not given the relaxation that spinal anesthesia gives, but has the advantage in the longer duration of its action.

Spinal anesthesia should be used carefully, if at all, in the hypertensive and sclerotic individual if operation is to be in the upper abdomen. It is in these cases that we have such a remarkable and dangerous fall in blood pressure. However, if the anesthesia can be kept low, such as is required for a prostatectomy, it is comparatively safe. It should not be used in the aged if regional or gasoxygen anesthesia will suffice, unless in these cases also the anesthesia is confined to the perineum or lower abdomen. It is not best to give it in the presence of active syphilis, in cerebral neoplasms, or diseases of the spinal cord. In skin diseases of the area to be injected, it should not be used. In cases with large empyemas or other diseases which diminish the respiratory capacity of the lungs, it probably should not be used. In cases with marked shock and in bullet wounds of the intestines involving the large bowels it is best to use some other type of anesthesia.

It is especially indicated in practically all the acute abdominal emergencies that demand surgery, in common duct and gall-bladder cases, in practically all suppurative diseases of the abdomen, in the presence of diabetes, pulmonary tuberculosis and other respiratory diseases; in almost all operations in the realm of the genitourinary surgeon; in operative obstetrics, especially in eclampsia when it is thought necessary to bring about immediate delivery; in all diseases of the liver or kidneys which usually contraindicate the use of ether; in fractures of the lower extremities and in inguinal and ventral hernias.

In a rather hurried review of the literature, I have made abstracts of the opinions of some of our most noted surgeons on spinal anesthesia. Judd⁸, of the Mayo Clinic: "I use spinal anesthesia extensively, and I am sure that in cases of diseases of the gall-bladder, particularly in cases of jaundice in which it is necessary to see the common duct, we have been able to save lives that we would not have saved if an ordinary general anesthetic had been used. The common duct can be exposed in a way that never was possible with general anesthesia."

Lahey⁹: "Spinal anesthesia in itself, in properly selected cases, is an ideal anesthetic. It produces conditions which permit abdominal surgery almost as on the cadaver, due to the quiet intestines and relaxed abdominal wall. In the hands of men who

will take the time to learn the technical methods of administrations, the dangers and how to prevent them, and the immediate emergency measures when they arise, spinal anesthesia is the most delightful and desirable anesthetic with which we have had any experience."

Erdman¹⁰, in an address on cancer of the rectum: "Spinal anesthesia is my choice. I can get a quieter field below, not having the tugging seen with general anesthesia. The shock is exceptionally slight. The reaction is wonderful. The patient is able to take nourishment even at his next meal hour and there is none of the after-vomiting and pulling on the perineum as seen with ether."

Jackson¹¹: "After an experience in over 1,000 cases we feel that its institution marks one of the most outstanding contributions to the development of surgery, both from the standpoint of the surgeon as well as the patient. This method has made surgery 25% simpler. Post-operative pneumonia, phlebitis, embolism and obstruction and other surgical complications have been reduced to a fraction with that observed with any form of general anesthesia."

Albee and Fry¹² state that all patients prefer spinal anesthesia if they have had a chance to compare it with ether. The mortality of spinal anesthesia lies between that of ether and chloroform. They are convinced that when injected properly and skillfully, combined with the judicious use of adrenalin and ephedrin, novocaine when injected intradurally will prove to be the safest of all known anesthetics. The complete relaxation of muscles and tissues permit maximum exposure in the field of operation in a joint.

Babcock¹³: "The chief value of spinal anesthesia is in operations of the lower abdomen and pelvis. Probably no other form of anesthesia yields as great a degree of muscular relaxation in these regions with so little danger. It is particularly valuable in acute peritoneal infections such as appendicitis. The lowest mortality I have obtained in operating on the appendix is 1.9% in a series of 220 consecutive and unselected cases, operated on promptly upon admission to the hospital, and irrespective of the degree or duration of any associated peritonitis, was secured with spinal anesthesia."

Cattel¹⁴ at the Lahey Clinic reviews the results of 345 cholecystectomies with a mortality of .9% as compared with 5.1% mortality in a previously reported series of 548 cholecystectomies. The use of spinal anesthesia in the former series is given as one of the causes of this great reduction in mortality.

Clute¹⁵, also of the Lahey Clinic, feels that spinal anesthesia represents the greatest advance in surgery in the last twenty-five years.

Rankin at the Mayo Clinic uses spinal anesthesia in practically all of his carcinoma of the colon patients and he feels that its institution is one of the outstanding causes of such a marked lowering in his mortality figures.

The purpose of these quotations is to show us what some of the best surgical minds in America think of this type of anesthesia and to make us realize that we are not doing our patients justice to continue the use of inhalation anesthesia in conditions where spinal is clearly indicated.

In post-operative paralytic ileus spinal anesthesia has proven to be very valuable when other methods of treatment have failed, and if the condition of the patient is not too grave. In mechanical obstruction it should not be used except as an anesthetic preparatory to operation. It has been stated that it might be used as a diagnostic aid to rule out or establish the diagnosis of mechanical obstruction; that in suspected cases of obstruction, if after its administration gas or fecal material are passed, mechanical obstruction could be ruled out. This idea is erroneous, as I pointed out in the April (1931) number of the Surgical Clinics of North America¹⁶.

In the realm of the obstetrician, spinal anesthesia has been found very useful. It abolishes any pathological as well as the normal tone of the cervix, which then becomes flaccid and dilates with great ease and rapidity either manually or spontaneously; the contractions of the body of the uterus become more vigorous, and the perineum becomes completely relaxed. It has no deleterious action on the child.

Spinal anesthesia is especially valuable if Cesarian section or instrumental delivery is performed in eclampsia, as it lowers the blood pressure which is dangerously high and has no deleterious action on the liver or kidneys.

Various forms of regional and local anesthesia have been used as a therapeutic agent in the convulsions of tetanus. Mandl¹⁷ reports six cases of full-fledged tetanus treated by the injection of procaine into the spinal canal. In every case, generalized convulsions ceased for a few hours; local spasms of the muscles of the lower extremities and of the abdomen were controlled and the patient welcomed the treatment. In some, the relief was lasting and initiated convalescence.

Koster and Kashman¹⁸ have reported several hundred cases in which spinal anesthesia has been used for surgery on the head and neck with apparent success. While I personally have had no experience in the use of spinal anesthesia for operations above the diaphragm, I believe that their experiments have shown us that we need have little fear of the dreaded respiratory failure and collapse should the anesthetic solution ascend to the medulla, provided we can be assured that the patient's brain is receiving an adequate supply of blood; this is accomplished by keeping the patient in the Trendelenberg position. With our present knowledge, however, I believe the advantages of such anesthesia in head and neck surgery does not warrant its use for operation in these regions. As a general rule, regional anesthesia or the gases are satisfactory in practically all head and neck surgery.

There are many preparations on the market for use in spinal anesthesia. Labot uses neocaine: Babcock formerly used stovaine, but recently has used novocaine crystals; spinocaine is used at the Deaver Clinic and by Sise at the Lahey Clinic. My experience has been with the latter, and this I have found entirely satisfactory.

Since coming to Tampa (June, 1931), I have used spinal anesthesia in about seventy-five patients, some of my own and some of other surgeons, with excellent results. There were no complications or fatalities. During this time, I have seen two ether deaths.

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SYPHILIS AND PREGNANCY

Obstetricians should ever be on the alert for syphilis. Its pernicious action is often discovered when least expected and is spread from one generation to another. Serological reactions have been proved unreliable during pregnancy and the early puerperium. Positive reactions should be repeated several times before they are accepted as proof of the disease. Negative reactions do not rule it out; in fact, they are more apt to occur in the pregnant syphilitic than in the non-pregnant. Routine blood Wassermann or Kahn tests should be made on all expectant mothers as soon as possible, the earlier the test the more dependable are the results.

Syphilis acquired at the time of conception or during the catamenia usually presents graver symptoms or forms than in the non-pregnant. The primary lesions are often larger, last longer, ulcerate more easily and frequently become phagedenic. The skin rash is more diffuse and widespread. Pregnancy occurring in a syphilitic woman aggravates the general symptomatology, increasing the anemia, and making more common digestive disturbances, headaches, heart disease, neuralgia and bone pains. Repeated abortions, premature or still births, are frequently the only indications of this disease in the mother, the first usually resulting from recent syphilis, the two latter from cases of long standing.

Treatment is paramount to both mother and fetus. As soon as the diagnosis is made treatment must be started. Neosalvarsan and mercury are the basic therapeutic agents with bismuth and the iodides in conjunction, especially if the disease be latent. There is no select time for this treatment except to begin as early as possible and treat vigorously and thoroughly. The obstetrician should watch closely for renal pathology frequently a serious complication and when present be ever so careful for the welfare of his patient.

MEETING OF THE PUBLIC RELATIONS COMMITTEE

The regular meeting of the Public Relations Committee was held at the San Juan Hotel, in Orlando, on December 6, 1931. The meeting was called to order during luncheon by Chairman H. C. Dozier. The following Committee members were present: Drs. H. C. Dozier, J. M. Irwin, J. S. McEwan, H. L. Pearson, and J. Ralston Wells. The following Executive Committee members were present: Drs. G. H. Edwards, M. J. Flipse, Gerry R. Holden, and W. H. Spiers. Dr. Stewart Thompson, Business Manager of the Journal, also attended.

The subject of the Press Article Column was fully discussed. Dr. Dozier proposed a set heading for the press articles when they are published, the same heading to top this column all the time. A discussion concerning the sentence: "Inquiries will be welcomed and promptly answered if addressed to the Florida Medical Association, Box 81, Jacksonville, Florida," arose as to the advisability of its being included in the heading. A discussion by Drs. Edwards, Flipse, and Holden ended in the final adoption, unanimously, of the following heading: "This column is sponsored each week by the Florida Medical Association.

These articles are intended to be of distinct help to the citizens of Florida from an authoritative source. Inquiries will be welcomed and promptly answered if addressed to the Florida Medical Association, Box 81, Jacksonville, Florida."

There have been approximately twenty papers bunded in, of about 400 words each, for press publication. It was moved by Dr. McEwan and seconded by Dr. Holden that these articles start in the press at once. Passed. The secretary was instructed to arrange them in chronological order and send them to the Business Manager of the Journal for release as per his arrangements. The time when these articles should appear was thoroughly discussed. Moved by Dr. Irwin and seconded by Dr. McEwan that the articles should appear in the Sunday editions insofar as possible. These articles, therefore, would leave the business manager's office on or before the Wednesday preceding the Sunday of publication. Passed.

Dr. Dozier explained the possible misunderstanding by our component county societies' secretaries of a notice recently sent out requesting the names of physicians who would and could speak over the radio. The other proposition with which this was confused was that of radio talks that were requested to be re-written in shorter form for press articles. The request for doctors who could and would talk over the radio is to enable our committee to form a list of men in all parts of the State, who would talk over the radio when called upon from time to time. It must be understood that this committee is not functioning for one month or one year, but it is laying the ground work for functioning on a much larger scale, as time goes on, for some years in the future. At present, we are doing the ground work, and literally re-writing and fitting articles to our own Florida needs from articles that have been previously used, largely by the Illinois State Societv. It is indeed a kindness for these component States to thus enable Florida to make a better start by using their articles and their experience of years back. These articles, however, will soon be exhausted, and Florida must build up her own library and use her own articles, so that we can function independently, and so that we can be in a position to help other State societies from time to time, as the States now functioning have helped us. With this end in view, we now request all county societies to send in articles, however short or long, that are of interest to the medical profession, which have appeared in their local society meetings, or which have been broadcast over local radio stations. These articles, that can be collected from the past, will be appreciated and the articles and talks that appear from time to time in the future should be sent in by the county society secretary to Dr. Wells, Daytona Beach, so that he may arrange them in their proper position, and thus keep up the sequence of press articles for the months and the years to come.

Three local radio broadcasting stations report as follows: Orlando is broadcasting every Tuesday and Thursday at 11 a.m.; Tampa has started; Miami started the week of December 7, 1931.

Meeting adjourned.

The next meeting of the Public Relations Committee will be called at a time and a place to be decided in conjunction with the Executive Committee and the Pre-Convention meeting.

J. Ralston Wells, M.D., Secretary, Public Relations Committee.

ST. PETERSBURG'S NEW HOSPITAL

St. Anthony's Catholic Hospital of St. Petersburg, owned and operated by the Sisters of the Third Order of Saint Francis, recently opened its doors to the public. The hospital is located on Seventh avenue north at Eleventh street.

The new hospital is the first Catholic institution of its kind on the West Coast and the second to be operated in Florida by the Sisters of Saint Francis. Mother Magdalena, who is in charge of the hospital, is a registered pharmacist and has wide experience in nursing and in hospital operation. Sisters of Saint Francis have been operating hospitals and schools for forty or fifty years. The Order now has two large schools at Jamaica, West Indies, two at Buffalo, two at Pittsburgh, four in New Jersey, two in New York and a hospital at Miami.

The building and property occupied by the St. Anthony's Catholic Hospital was purchased several months ago, having formerly been known as the Faith Hospital, which was accredited by the American College of Surgeons. The building has been entirely renovated and improved both inside and out. All guest rooms have been redecorated and the interior has been painted throughout. The old system of having everything white in a hospital has been changed and attention has been paid to making the institution homelike with the use of colors in the rooms. The grounds, occupying the entire block between Sixth and Seventh avenues, have been beautified; a large number of shrubs and plants have been given to the new institution.

St. Anthony's Hospital will have a capacity of fifty-five beds to begin with but it is expected that this will be increased as the institution grows.

The private office of the Mother Superior will be adjacent to the entrance hall. The elevator connecting the three floors is in front of the entrance, also the central telephone exchange. Provisions will be made for the installation of a telephone in any room. The children's ward, physiotherapy departments, orthopedic room, a completely equipped kitchen and a receiving room for emergency cases will be located on the first floor.

The first and second floors will be devoted largely to guest rooms, private and semi-private. Rooms containing two or four beds will replace the former large wards, while private rooms with bath and special accommodations for private nurses will take up the balance of the space. 'The drug room, supply room, diet kitchen, Sisters' dining room, large nursery and solarium will also occupy the second floor.

On the third floor will be located two large operating rooms for major operations. These rooms contain the most modern of hospital equipment. On this floor will also be located the delivery room, genito-urinary room, and special room for eye, nose and throat examinations. The operating rooms on the third floor will be far removed from the patients who occupy rooms on the first and second floors.

The nurses' home, a separate building south of the main hospital building, has been entirely renovated and equipped with new furniture. All interior walls have been tinted and woodwork painted throughout. The exterior is finished in a buff stucco.

The hospital staff will be named after the institution has been in operation for some time.

SECTIONAL MEETING OF THE AMERICAN COLLEGE OF SURGEONS

A general invitation is extended to all members of the medical profession of the state to attend the Alabama, Florida, Georgia, Louisiana and Mississippi Sectional meeting of the American College of Surgeons, to be held in Jacksonville at the Mayflower Hotel on February 1st and 2nd, 1932.

The committee on local arrangements in Jacksonville with the cooperation of the College headquarters are making ever possible effort to secure a highly instructive and interesting meeting. The general outline of the program announced is as follows:

MONDAY, FEBRUARY 1, 1932.

7:30 to 8:30 A.M.—Registration at the Mayflower Hotel.

8:30 to 11:00 A.M.—Operative Clinics and demonstrations in general surgery and the surgical specialties at local hospitals.

11:30 to 12:30—Clinical address by an outstanding visiting surgeon.

9:30 to 12:00 Noon—Hospital Round Table conference.

2:00 to 4:30 P.M.—Hospital Standardization Conference for members of medical staffs, trustees, superintendents, nurses and others interested in hospital work.

4:30 to 5:00 P.M.—Annual meeting of the Fellows of the College.

6:30 to 10:00 P.M.—Dinner and sound medical motion picture exhibition.

Tuesday, february 2, 1932.

8:30 to 11:00 A.M.—Operative Clinics and demonstrations in general surgery and the surgical specialties at local hospitals.

11:30 to 12:30—Clinical address by an outstanding visiting surgeon.

9:30 A.M. to 12 Noon.—Demonstrations and Round Table Conference on hospital departmental problems at one of the local hospitals.

2:00 to 5:00 P.M.—Scientific Meeting.

2:00 to 4:30 P.M.—Demonstrations and Round Table Conference on hospital departmental problems at one of the local hospitals.

8:00 to 10:00 P.M.—Community Health Meeting.

A number of distinguished surgeons, health leaders, and hospital authorities, from outside of the state included in the section will be brought by the College to Jacksonville on this occasion to participate in the program.

On Monday evening it is to be especially noted that there is a dinner to which all of the medical profession is cordially invited. Following this dinner there will be a most interesting exhibition of sound medical motion pictures. Full details of the program will appear later.

STATE NEWS ITEMS

The annual meeting of the Southern Medical Association will be held in Birmingham, Alabama, November, 1932. The total registration at the meeting of the Association in New Orleans, November 18-20, was 2,087; 1,426 physicians, 225 medical students and 436 ladies. There were

56 registered from the Florida Medical Association as follows:

Ames, A. M
Blackmar, R. W Jacksonville
Britt, ReddinSt. Augustine
Ditti, Reddill D. 11 '
Brinson, W. D
Burch, R. N
Chapman, B. A Jacksonville
Clark, Haynsworth DFt. Pierce
Colson, J. H
Constitution of the consti
Copp, F. A Jacksonville
Dailey, I. AMicanopy
Davis, J. C Quincy
Dickinson, J. C
Driskell, S. E Jacksonville
Dunaway, C. E
Estes, James L
Flipse, M. JayMiami
Gachet, N. L
Gilmer, E. S
Greene, Ralph N Jacksonville
Hanson, HenryJacksonville
Holloway, Luther W Jacksonville
Holmes, Roy J
Howe, Roy Daytona Beach
Jelks, Edward
Jobson, A. M. C
Johnson, M. FFt. Myers
Lester, John GLakeland
Limbaugh, LouieJacksonville
Lischkoff, M. A
Lowry, J. B
Maines, John E Lake Butler
Manning, William S Jacksonville
Miller, R. L
Moor, F. C
Nichol, E. Sterling
Nobles, Robert GPensacola
Norris, S. R. Jacksonville Oetjen, George Frederick Jacksonville
Oetien, George Frederick
Paul, L. HBonifay
Pearson, Rufus J Miami
Pound, J. HChattahoochee
Quillian, Warren
Quina, M. EPensacola
Royce, Clayton Elbert
Shaw, E. Clav
Smith, Marvin H
Taylor, H. M
Thames, RufusMilton
Thomas, W. C
Thompson, StewartJacksonville
Turberville, J. I
Van Schaick, Harold D Jacksonville
Watson, HermanLakeland
Webb, Carol C
Wells, J. Ralston
Whitaker, C. D
* * *

The Escambia County Medical Society, at a meeting held on November 10th, had as guests members of the Walton-Okaloosa County Medical Society, doctors from the Naval Air Station and Naval Dispensary and members of the Escambia County Medical Society of Alabama. During the scientific session, an article on "The Use of Local Anesthesia in the Treatment of Fractures" was read by Dr. James M. Hoffman and discussed by those present. Dr. Alvyn W. White read a paper on "Some Observations on the Treatment of Empyema in Children by Aspiration," which was also liberally discussed. Supper was served after the scientific meeting.

J. BROWN FARRIOR

Dr. J. Brown Farrior of Tampa died at his home on October 3rd after an illness of several months. He was fifty years old.

Dr. Farrior, a native of Alabama, was graduated from Southern University, Greensboro, Alabama, in 1902 and from Tulane Medical College in 1905. He afterward took a post-graduate course at the University of Chicago, specializing in diseases of the eye, ear, nose and throat, graduating in 1911, in which year he came to Tampa and began practicing his profession. He was active in the Hillsboro County Medical Society and was immediate past president of that organization. He also took an active part in other civic efforts, being one of the original sponsors of the new Municipal Hospital and indefatigable in his labors to bring about the passage of the bond ordinance that resulted in the building and equipment of the hospital.

It was said of Dr. Farrior that fully half of his practice was among those who were unable to pay for the services of a specialist. He was a member of Tampa Rotary Club, Hillsborough Lodge No. 25, Free and Accepted Masons, Tampa Consistory No. 1, Scottish Rite Masons, and Egypt Temple of the Shrine. Surviving are the widow, three daughters, Evelyn, Julia and Sarah; three sons, J. B., Jr., Searcy and Richard; his parents, Dr. and Mrs. Joseph R. Farrior of Chipley; two sisters, Mrs. W. A. McLeod of St. Petersburg and Mrs. M. S. Huggins of Chipley; and four brothers, W. L. and Dr. Goode Farrior, Chipley, and Dr. Hugh and J. Rex Farrior of Tampa.

Dr. and Mrs. Alva Justin Floyd, Palmetto, announce the birth of a son, Alva Justin, Jr., on October 5th.

* * *

Dr. Ralph N. Greene, Jacksonville, served as head of the Speakers' Bureau for the Community Chest Campaign in Jacksonville during the month of November. Jacksonville's chest budget of \$300,000 was subscribed in full with a substantial surplus promised.

* * *

Dr. and Mrs. Bailey Brown Sory, Jr., West Palm Beach, announce the birth of a daughter, Anne Long, on October 18th at the Good Samaritan Hospital. The annual meeting of the Florida Midland Medical Society took place Wednesday, October 28. A very interesting all-day program was enjoyed by an unusually large attendance. Program follows:

- "Hay Fever in Florida"—Dr. Frank C. Metzger, Sarasota. Discussion opened by Dr. R. L. Cline, Lakeland.
- "Urethral Obstruction"—Dr. James L. Estes, Tampa. Discussion opened by Dr. Robert L. Henderson, Tampa.
- "Tuberculosis in Children"—Dr. William E. Sinclair, Orlando. Discussion opened by Dr. Allen F. Higgins, Tampa.
- "Perforation of Gastric and Duodenal Ulcers"
 —Dr. W. D. Suggs, Bradenton. Discussion opened by Dr. Herman Watson, Lakeland.
- "The Examination of Urine"—Dr. J. A. Pines, Orlando. Discussion opened by Dr. H. A. Day, Orlando.
- "Poliomyelitis"—Dr. H. Mason Smith, Tampa. Discussion opened by Dr. James Boulware, Lakeland.

Adjourn for Turkey Dinner at Manavista Hotel.

AFTERNOON SESSION

- "The Treatment of Colitis"—Dr. Nathaniel L. Spengler, Tampa. Discussion opened by Dr. W. E. Sherman, Winter Haven.
- "Ultra Violet Ray"—Dr. W. J. Johnston, Sarasota. Discussion opened by Dr. L. L. Andrews, Orlando.
- "Skull and Brain Injuries"—Dr. John R. Boling, Tampa. Discussion opened by Dr. L. W. Blake, Bradenton.
- "Incidence of Rheumatic Heart Disease in Florida"—Dr. E. W. Bitzer, Tampa. Discussion opened by Dr. J. W. Alsobrook, Plant City.
- "Angina Pectoris"—Dr. T. M. Rivers, Kissimmee. Discussion opened by Dr. T. A. Neal, Orlando.
- "Electrocoagulation Tonsillectomy"—Dr. L. W. Blake, Bradenton. Discussion opened by Dr. W. J. Johnston, Sarasota.
- "Lung Abscess—Report of Cases Treated by Bronchoscopic Drainage"—Dr. Joseph W. Taylor, Tampa.
- "Clinical Cases"—Dr. J. F. Mason, Bradenton.

 Over fifty doctors were in attendance and it is claimed to have been the best meeting held for many years. A list of those attending the meeting

was not submitted for publication. Dr. G. H. Edwards, president of the Association, gave a short talk on "The State Association" and Dr. Joseph Halton of Sarasota discussed the coming state convention in May. Dr. J. W. Taylor, Tampa, was elected president; Dr. L. W. Blake, Bradenton, first vice-president; Dr. John R. Boling, Tampa, second vice-president; and Dr. Robert C. Black, Plant City, secretary-treasurer. Tampa was chosen as the 1932 convention city.

* * *

Dr. and Mrs. Robert E. Gilbert, Winter Haven, announce the birth of a daughter, Shirley, on September 12th.

* * *

In the November Journal, page 244, the name of Dr. J. Ralston Wells was inadvertently omitted in connection with the meeting of the Public Relations Committee held on October 8th at Gainesville.

* * *

Dr. George W. Wood of Rockledge died at his home November 9th.

* * *

Dr. and Mrs. Robert Preston Henderson, Tampa, announce the birth of a son, Richard Miller, on October 29th at the Tampa Municipal Hospital.

* * *

Dr. E. W. Warren, Palatka, is now practically recovered from the results of an automobile accident in which he sustained a broken leg and other injuries. Dr. Warren is now in his office after almost three months of confinement to bed. He is secretary of the Railway Surgeons Association and is also secretary of the Putnam County Medical Society.

* * *

Dr. W. M. Shaw and family spent the Thanksgiving holidays in Sumter, South Carolina, with Dr. Shaw's mother.

* * *

Dr. William E. Westcott, formerly of Orlando, is now located at Candler, North Carolina.

* * *

Dr. Clifford G. Blitch, Jacksonville, was appointed by the Duval County Welfare Board as an associate in the department of tuberculosis at the Duval County Hospital recently.

Dr. and Mrs. S. Ward Fleming, West Palm Beach, recently returned from a six weeks' motor trip through the middle west. During this time Dr. F'eming attended surgical clinics in Barnes Hospital, St. Louis.

* * *

Dr. J. W. Hodges, who will be remembered as house physician at the Quisisana Hotel, Green Cove Springs, from 1912 to 1920, has just been retired from the United States Veterans' Hospital at Hines, Illinois. Dr. Hodges has completed eleven years' service with the government and has returned to Florida where he expects to locate as a retired physician.

* * *

Dr. H. L. Merryday, Daytona Beach, has been retained as chief of staff of the Halifax District Hospital for another year and Dr. Joseph H. Rutter, city physician, was re-elected secretary.

* * *

Mr. Sigmond Harris, 81, retired cotton merchant of Eastman, Georgia, died November 17th at the home of his son, Dr. Herrman H. Harris, Jacksonville, Florida.

* * *

The Florida Radiological Society was formally organized on November 14, 1931, at a meeting held in St. Petersburg under the chairmanship of Dr. L. W. Cunningham of Jacksonville. A constitution and by-laws were adopted at the organization meeting. The following officers were elected to hold office until the spring meeting, 1932:

President—L. W. Cunningham, Jacksonville.

Vice-President—O. O. Feaster, St. Petersburg. Secretary-Treasurer—Frederick K. Herpel, West Palm Beach.

Mectings of the society will be held in May and November, the May meeting being held the day before the meeting of the Florida Medical Association. The radiologists of Florida have been meeting twice yearly, informally, for the discussion of their problems. The newly formed organization but makes a permanent organization and increases the scope of its activities.

* * *

An examination by the American Board of Otolaryngology was held in Indianapolis, Indiana, September 12, 1931, just prior to the meeting of the American Academy of Ophthalmology and Otolaryngology held in French Lick, Indiana. Forty-three candidates were examined, of which nine were conditioned or failed. The Board will hold an examination in New Orleans on May 9th, during the meeting of the American Medical Association, and in Montreal, next fall, just prior to the session of the American Academy of Ophthalmology and Otolaryngology. Prospective applicants for certificates should address the Secretary, 1500 Medical Arts Building, Omaha, Nebraska, for proper application blanks.

* * *

Dr. Ernest Milam, Jacksonville, was a visitor in West Palm Beach recently.

* * *

The American Board for Ophthalmic Examinations will hold an examination in New Orleans on Monday, May 9th, 1932, at the time of the meeting of American Medical Association. Applications for this examination may be procured from the Secretary, 122 South Michigan Boulevard, Chicago, Illinois. Your application should be sent in at least sixty days prior to the date of the examination.

* * *

Dr. Ralph N. Greene, Jacksonville, has been appointed on the contest committee of the fourth annual Miami All-American air races to be held in January. Dr. Greene has served in an official capacity in a number of record-breaking aviation trials held under the sanction of the National Aeronautical Association and will act as chairman of the technical committee for the Miami meet.

* * *

The Pasco-Hernando-Citrus County Medical Society held its regular monthly meeting with Dr. T. F. Jackson in Dade City, Thursday evening, November 12th. After dinner at the Gray Moss Inn Hotel, Dr. G. H. Edwards, president of the State Association, spoke on the general working of the Florida Medical Association and of the plans for the next state medical meeting to be held in Sarasota, May, 1932. Dr. Edwards explained the work of the Public Relations Committee of the Association and requested the full cooperation of the Society. He also presented a paper on "Surgical Operations Dealing with Diseases of Women." Dr. G. R. Creekmore and Dr. T. F. Jackson made reports of the organization and activity of the Pasco-Hernando-Citrus County Medical Society. Dr. W. H. Spiers of Orlando spoke very encouragingly of the Society's work. Upon Dr. Furlow's invitation to the Society to meet with him in Brooksville in December, the meeting adjourned. Those present were Doctors J. T. Bradshaw, A. B. Cannon, G. R. Creekmore, L. H. Dame, L. T. Furlow, T. F. Jackson, G. H. Edwards and W. H. Spiers.

* * *

Dr. Edward Jelks, Jacksonville, was recently chosen president of the Jacksonville Historical Society.

Dr. J. R. McEachern was recently appointed city health officer for Tampa. Dr. McEachern succeeds Dr. Charles W. Bartlett, Jr., in this office.

* * *

Dr. and Mrs. Councill Courtland Rudolph, St. Petersburg, announce the birth of a son, Councill Courtland, Jr., on October 11th at the Tampa Municipal Hospital, Tampa.

* * *

The annual meeting of the Duval County Medical Society was held at the Hotel Mayflower, Tuesday evening, December 1st. Dr. Robert McIver was elected president of the Society; Dr. Kenneth Morris, vice-president; Dr. F. L. Fort, secretary, and Dr. E. C. Swift, treasurer. Dr. Luther Holloway, the retiring president, was elected to serve on the Board of Governors. The following doctors were elected as delegates to the House of Delegates of the Florida Medical Association: Luther Holloway, Gerry Holden, Ferdinand Richards, H. Marshall Taylor, W. M. Shaw, George Richardson, Clayton E. Royce and Kenneth Morris. Doctors W. W. Kirk, B. F. Woolsey, Edwin C. Swift and F. L. Fort were elected as alternate delegates.

* * *

Dr. and Mrs. Charles Edgar Creel, Pahokee, announce the birth of a daughter, Patricia Ann, on October 15th at the Good Samaritan Hospital, West Palm Beach.

* * *

Dr. and Mrs. Shaler Richardson, Jacksonville, announce the arrival of a baby girl, Saturday, December 12th.

* * *

Dr. J. F. Cranford announces the removal of his offices from the Florida National Bank Building to Rooms 503-504 Sumner Building, St. Petersburg.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, 1NC.

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Mrs. Edward Jelks,

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Jacksonville

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THE S. M. A. CONVENTION AT NEW ORLEANS, LOUISIANA

Our Florida Auxiliary should indeed feel proud of the honors which were accorded two of its members at the meeting of the Woman's Auxiliary to the S. M. A., held in New Orleans in November. Our President, Mrs. S. E. Driskell of Jacksonville, was elected first vice-president, and our Past President, Mrs. J. Ralston Wells, of Daytona Beach, was appointed chairman of organization. We are happy that both of our State Presidents should be so signally honored.

In this month's issue, we shall only attempt to report the activities of the Auxiliary to the S. M. A. in convention assembled, but hope next month to tell of some of the splendid and delightful entertainments which were provided by our hostesses, the Louisiana Auxiliaries.

The eighth annual meeting of the Woman's Auxiliary to the Southern Medical Association was held in New Orleans, Louisiana, at the Roosevelt Hotel, on Nov. 18, 19, 20, 1931. The Convention began at 10 o'clock Wednesday morning with the meeting of the Executive Board. This was followed by a luncheon at 12:30, to which all women attending the meeting were invited. The decorations for this luncheon were beautiful, especially the table of the honor guests and officers. Mrs. Collom, the President, who presided,

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was presented with a huge basket of pink roses and each honor guest was given a shoulder bouquet of orchids.

After the invocation by the Rev. Matthew Brewster, Rector of St. Andrew's Episcopal church, New Orleans, came the address of welcome by Mrs. S. M. Blackshear, President of the Auxiliary to the Orleans Parish Medical Society. This was followed by greetings from the Louisiana State Auxiliary, given by its President, Mrs. H. W. E. Walther of New Orleans. The response to these speeches was to have been given by Mrs. Geo. A. Hendon, of Louisville, Kentucky. Mrs. Hendon was unable to be present, so at the last moment her place was filled by an excellent "pinch-hitter," Mrs. J. Ralston Wells, of Daytona Beach, Past President of our Florida State Auxiliary.

At this time, Dr. Felix J. Underwood, of Jackson, Miss., President of the S. M. A., was presented by Mrs. Collom. After bringing greetings from the S. M. A. he gave a most inspiring talk and commended highly the work of the Auxiliary.

Among the honor guests were Mrs. A. B. Mc-Glothlan, of Missouri, President of the Woman's Auxiliary to the American Medical Association, and Mrs. Felix J. Underwood, wife of the President of the Southern Medical Association.

Mrs. Collom asked Mrs. Seale Harris, of Birmingham, Ala., who was the first president of the Woman's Auxiliary to the S. M. A. (Mrs. Collom spoke of Mrs. Harris as the "Mother" of this organization), to introduce in turn the former presidents, who were present. Each of these gave a three-minute talk on the "Good of Our Auxiliary." The meeting then adjourned, until the business meeting next morning.

GENERAL BUSINESS MEETING

The general business session of the Woman's Auxiliary to the Southern Medical Association was held in the Tip Top Inn of the Roosevelt Hotel, New Orleans, Thursday, November 19th, beginning at nine o'clock in the morning.

The meeting was called to order by the President, Mrs. S. A. Collom. The invocation was by Father F. B. Carbajal, of the Church of the Immaculate Conception. Mrs. W. R. Buffington of New Orleans told of the various entertainment planned.

Mrs. F. M. Johns of New Orleans reported a total of 503 women registered; 225 of this number being from the hostess city.

Mrs. A. B. McGlothlan, president of the Woman's Auxiliary to the A. M. A., brought greetings. She spoke of Auxiliary work first, as



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a means of promoting good fellowship among the doctors themselves and among their families; second to encourage worthy philanthropic work, such as a medical benevolent fund, student loan fund, preventorium and general child welfare work; third to stress health education of the laity through its various health programs, and to emphasize the importance of placing Hygeia in every reading room, school, and home possible in order to offset literature of various faddists and cults.

Mrs. Collom gave her report as president, and urged the Auxiliary to help create a stronger desire for health. She left the wish that the aims an l purposes of the organization might grow stronger and brighter and more helpful.

Mrs. C. W. Garrison of Little Rock, Ark., reported that the Southern Auxiliary now has a membership of 4,947, and Texas had shown the largest gain during the past year.

Mrs. A. A. Herold of Shreveport, La., read the courtesy resolutions.

Mrs. C. E. Oates, of Little Rock, gave a report of the medical history sent in from every state. This was most interesting and enlightening and gave promise of more yet to come.

It was voted that each state continue to send in data on its various medical heroes, and when sufficient material has been collected, it be published in book form.

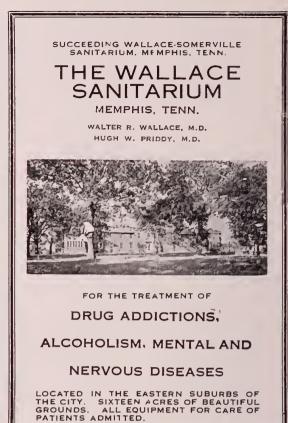
The following state presidents were present and were introduced by Mrs. J. B. White of Atlanta; Mrs. Perdue of Alabama, Mrs. Brookshire of Arkansas, Mrs. Driskell of Florida, Mrs. Walther of Louisiana, Mrs. Mason of Mississippi, Mrs. Cragg of Tennessee, and Mrs. Brindley of Texas. Each one gave an inspirational report of work done in their states. Other presidents sent reports to be read by alternates.

Dr. E. H. Cary of Dallas and Dr. Seale Harris of Birmingham, members of the advisory committee, spoke briefly and encouraged the Auxiliary to go forward with its work.

The nominating committee, composed of Mrs. Seale Harris, Mrs. D. J. Williams of Mississippi, Mrs. D. A. Rheinhart of Arkansas, and Mrs. A. T. McCormack of Kentucky, presented the following slate which was adopted and officers elected as a whole:

President—Mrs. C. E. Oates, Little Rock, Ark. President-Elect—Mrs. A. A. Herold, Shreveport, Louisiana.

First Vice-President—Mrs. S. E. Driskell, Jacksonville, Fla.



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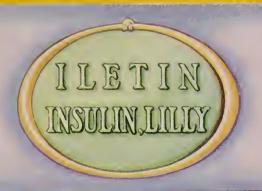
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Custodian of Records—Mrs. A. T. McCormick, Louisville, Ky.

Parliamentarian—Mrs. J. D. Perdue, Mobile, Ala. Mrs. Collom presented the gavel to Mrs. Oates and the meeting adjourned.

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3011	EDULE OF MEETINGS—C	APPRINGS				
COUNTY	SECRETARY	Date	MEI Time	ETINGS	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gamesville.	2nd Tuesday		White House	Yes.	77%
Bay	D. M. Adams, M.D., Panama City.					100%
Brevard	1. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		90%
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	2nd Tuesday	8:00 P.M.	Chamber of Com-	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday.	7:30 P.M.	Blanche Hotel		83%
Dade	Jos. S. Stewart, Jr., M.D., Miami.	1st Friday	8:30 P.M.	Club Room, Huntington Bldg.	Occasionally.	86%
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	100%
Duval	Kenneth A. Morris, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	89%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	89%
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st and 3rd Tues- days	8:00 P.M.	Tampa Municipal Hospital	No.	84%
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	100%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes	100%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	90%
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	83%
Madison	Geo. O. Davis, M.D., Madison.					68%
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tues. Oct. to May; 2nd Tues. May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	100%
Marion	Thos. H. Wallis, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	77%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies .	No.	100%
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	4tlı Monday	8:00 P.M.	Good Samaritan Hospital	Yes.	88%
Pasco- Hernando- Citrus	Geo. R. Creekmore, M. D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thursday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	54%
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.		Lakeland	Yes.	96%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	75%
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeesho- bee-Indian River-Martin		3rd Thursday	8:00 P.M.	Varies	Yes.	77%
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	100%
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	100%
Volusia	J. Ralston Wells, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	94%
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%
Washington- Holmes						25%
	NOTE-Secretaries: I	Please submit inform	nation to com	plete the above sche	dule.	

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

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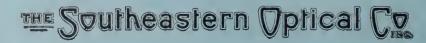
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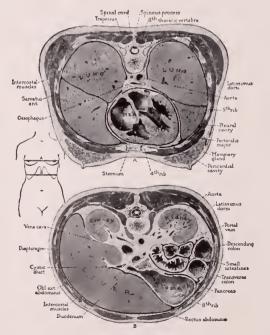


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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XVIII Jacksonville, Florida, January, 1932

Number 6

THE IMPORTANCE OF THE X-RAY
EXAMINATION OF THE NASAL
ACCESSORY SINUSES IN
CASES WITH CHRONIC
COUGH*

J. C. Dickinson, M.D., Tampa.

Chronic cough is one of the common complaints for which patients seek relief. A chronic or recurrent cough is always a source of annoyance to the patient and anxiety upon the part of his friends and family. The question of tuberculosis is always of first importance. Often if this can be answered in the negative the importance of the cough is unrecognized and little or nothing is done to locate and remove its real cause. The effort to recognize tuberculosis early has rather served to minimize the importance of other conditions which may be responsible for the cough which, if allowed to go unrecognized and untreated, may lead to conditions quite as serious as tuberculosis.

My interest in chronic sinus infections has been greatly stimulated by seeing many patients who were referred for an X-ray examination of the chest with a working diagnosis of tuberculosis. When nothing suggestive of tuberculosis could be found, we have, in many instances, been able to demonstrate pathology in the sinuses and have seen the cough and clinical evidence of tuberculosis disappear when appropriate treatment of the nasal accessory sinuses was instituted.

The cough accompanying sinus infection may be the result of chronic pharyngitis or laryngitis set up by the irritating post nasal discharge, or to secondary involvement in the bronchi and lungs.

The manner in which sinus infection reaches the lungs has been amply proven. This occurs both through lymphatic and by direct drainage. The course of lymphatic drainage is by the cervical and mediastinal lymph channels to the lung root. The direct drainage occurs principally at night when infectious material is directly aspirated by way of the trachea and bronchi. This has been proven by injecting lipiodol into the sinuses and demonstrating, by X-ray, its presence in the bronchial tree the following morning.

In children, especially, I believe that the importance of nasal accessory sinus infections is not given due consideration; children suffering from repeated colds, under-nourished, tuberculous suspects, with persistent coughs, (their tonsils and adenoids have almost invariably been removed, the tonsils being accused of more sins than the appendix.) Many of these children when their sinuses are examined show extensive pathology; their cough disappears and their general condition returns to normal when proper treatment is instituted. I have seen extensive lung changes secondary to sinus infection in quite young children. The longer these conditions go unrecognized the more extensive and permanent the changes. The X-ray is particularly valuable in children, the sinuses being small other methods of examination give little or no information as to the condition present.

Bronchiectasis has been looked upon as an incurable condition. Ochner has shown that if the condition is recognized early that by appropriate treatment in these cases, complete cure can be accomplished and all clinical and radiographic evidence of the disease will disappear. There is no clinical picture more distressing than the patient with a well-established bronchiectasis, who goes on year after year with a persistent harassing cough and copious expectoration. These cases gradually grow worse with repeated acute exacerbations, they run temperature, have hemorrhages, and there is little to distinguish them clinically from tuberculosis. They finally die after a prolonged period of invalidism. Even the fairly advanced case can be materially benefited if the foci of infection in the sinuses are eliminated and proper bronchial drainage instituted.

The properly made roentgenograms offer the only means of obtaining accurate information as to the existing sinus pathology. The normal sinus picture is very characteristic and any variation from this represents pathology or developmental peculiarities. It has been my experience that the opinion of a competent roentgenologist as to existing sinus pathology is usually verified at operation if the operation is done in such a manner that a fair opinion as to the pathology present can be obtained. In most instances very accurate differen-

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

tiation can be made. The presence of cysts or polypi can be plainly demonstrated; chronically thickened mucous membrane with its accompanying osteitis produces a very characteristic picture. The acute and chronic empyema can, in most cases, be readily differentiated. With accurate information the rhinologist is in position to advise proper treatment.

I have found that the injection of opaque oil into the sinus is unnecessary in most cases and of little aid. I would add a note of warning as to the allergic reaction that may follow the injection of oil. I have seen very marked swelling of the mucous membrane following its use and the condition may last for days causing a great deal of discomfort to the patient.

I am not going into the technique of making satisfactory roentgenograms of the sinuses. The necessity of careful attention to detail is fully appreciated by every roentgenologist of experience. Roentgenograms of less than the best quality are worse than none at all, the greatest danger being that pathology is read into the films where if correct technique had been used in the examination and the interpretation made by some one of experience, no pathology would have been found. The only way that this experience can be gained is by the constant cooperation between the roentgenologist and the rhinologist. The roentgenologist must understand the pathological changes that he is interpreting and should in every case, where possible, be present at the time of operation and see the pathology found. If this cannot be carried out, a careful post operation check between the roentgenologist and the rhinologist is important. It is the lack of cooperation that is responsible for probably all of the disagreements that have occurred.

CONCLUSIONS

- 1. The nasal accessory sinuses are frequent'y the location of foci of infection that are responsible for chronic lung pathology.
- 2. In many cases extensive sinus pathology will be demonstrated by X-ray examination where there is little if any local evidence.
- 3. If permanent changes are to be avoided, it is important that these foci be located early and proper treatment instituted.
- 4. The only means of obtaining accurate preoperative information as to existing sinus pathology is by properly made and interpreted roentgenograms.

DISCUSSION

Dr. F. K. Herpel, West Palm Beach:

This paper of Dr. Dickinson brings a very important message, I feel, to the men doing general practice and also to the rhinologist. One is astounded at the frequency of sinus pathology in both children and adults in whom the only symptomatology is a general rundown condition with chronic cough. No patient should ever, in my estimation, be dismissed (having been referred for examination of the chest in which the findings are negative or only doubtful or suspicious) without having a roentgenographic examination of the accessory sinuses, also.

I note that Dr. Dickinson has experienced some antagonism incident to the extra expense involved as a result of these examinations. You do not have to give the patient the diagnosis, but explain to him that you consider it essential to do this examination as a help in arriving at the correct diagnosis. Positive lung findings are infrequent in many of these cases, but sinus infections can be easily demonstrated. One very definite mode of infection seems to be in addition to those mentioned by Dr. Dickinson, and it is quite common in tuberculosis. As I understand the etiology, it is due to absorption in the lower esophagus of organism infected lymph which has dropped down, causing a hyperplasia which produces cough. It is more or less a pressure type of cough.

I believe it is also important in cases of children in whom the tonsils are acknowledged to be the causative factor in the production of cough. If you will examine the nasal accessory sinuses you will find that many are suffering from chronic sinus infection. It is a very important thing in tonsillar pathology.

In mastoiditis, likewise, particularly in children, I find it of great importance to take sinus films. The rhinologist with whom I work most of the time desires sinus films in all of these cases. Many times acute mastoiditis is associated with acute sinusitis.

Undoubtedly the proper conservative treatment of infected sinuses in children particularly will result in marked clinical improvement, and other procedures are not often necessary.

I agree with Dr. Dickinson as to the use of opaque media for examination of the nasal accessory sinuses. It is very infrequently necessary, because the proper film technically offers us just as much. You can interpret it just as accurately,

and in many cases I believe more accurately than with the opaque medium. I think injections should be avoided in these cases.

I appreciate very much the opportunity of participating in the discussion of this important paper.

Dr. H. Marshall Taylor, Jacksonville:

The subject of sinusitis and cough is one of intense interest and the Society is indebted to Dr. Dickinson for bringing this subject before us today. Every child or adult who has a persistent cough should have a thorough examination of his or her sinuses made. The report of the roentgenologist, as a rule, is of tremendous assistance in the diagnosis of sinus disease. In my experience, however, a negative report of the roentgenologist does not always exclude sinus disease, particularly in the very acute or fulminating cases.

In my own experience I have had three cases of acute frontal sinus disease in which the roentgenologist reported a normal frontal sinus and within less than thirty-six hours of his examination there was a rupture of the frontal sinus abscess into the orbit. Consequently, I cannot feel that a negative report of the roentgenologist always excludes sinus disease. The principal value to me of the findings of the roentgenologist deals particularly with his report of the size of the frontal sinus, the depth of the supraorbital recess and his report and findings of the sphenoid.

I feel that the vast majority of cases of disease of the sinuses if properly studied can be diagnosed by anterior and posterior rhinoscopy alone. first inspection of the nose in the case of sinus disease frequently there may be no evidence of secretion. However, if the turbinal bodies are contracted with the use of such solution as ephedrin, adrenalin or cocaine and after waiting a few moments the head is tilted forward almost to the floor, within a few minutes you can nearly always see the presence of pus in the middle meatus and coming down between the middle turbinate and the outer wall of the nose. This can nearly always be observed if the frontal sinus, the ethmoidal cells or maxillary antrum are the seats of suppuration. Posterior rhinoscopy in the vast majority of cases of disease of the sinus will also reveal the presence of pus. In the last analysis, however, no examination of the sinus is entirely complete without the combined study of both the sinuologist and the roentgenologist.

COLONIC DIVERTICULA IN RELATION TO CARCINOMA AND ITS PREVENTION*

ROSALIE SLAUGHTER MORTON, M.D., Winter Park.

In presenting this paper I hope to place before you items which you will find of interest in relation to the early diagnosis and treatment of colonic diverticula, which through prolonged chronic irritation or through ulceration, and the resultant cicatrix, may form a base for the development of carcinomatous proliferation and degeneration. Diverticulitis often also causes, before it attracts attention as responsible for so doing, toxemia, with its attendant anemia, depression, and lowered vitality, which lessen the resistance of the system to malignancy.

To increase the efficiency of persons from forty to sixty is a civic duty, as in these years the best public service is usually rendered. To remove the apprehension of cancer, even from one source, during the years which should be the most satisfactory to a man or woman; and because a number of cases of diverticulitis have come under my care, are the reasons I have chosen this subject for today's paper. The early diagnosis and early medical treatment of diverticula prevent the development of the steps which may lead to carcinoma, reduce the vague feeling of discomfort and increasing physical and mental weariness which baffle many otherwise energetic people. Through the prevention of diverticulitis many other forms of illness may also be prevented, such as the majority of cases of fistula between the urinary bladder and the bowel, between contiguous portions of the colon and to the surface of the abdomen, as well as a frequent type of colonic obstruction and cases of local and general peritonitis.

Pain caused by diverticula may be referred to the upper abdomen and cause a diagnosis of cholecystitis or duodenal irritation. Obscure diagnoses are often made clear by the roentgenological discovery of inflamed diverticula. For example: cases thought to be hyperplastic tuberculosis gastric or duodenal ulcer, chronic or acute inflammation of the gall-bladder, appendicitis, actinomycosis, intestinal indigestion, syphilis, inflammatory pelvic disease, transposed appendix, colitis, sigmoiditis, as well as carcinoma have all been found to be misdiagnosed diverticulitis and have cleared up with its proper treatment; as have also, cases

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12-13, 1931.

of rheumatism, acute and subacute arthritis, endocarditis, and other illnesses due to local foci which have been attributed to tonsillar, dental, or sinus infections. Diverticula in all stages of development or degeneration can easily be recognized through roentgenology. Medical treatment is simple and if continued conscientiously by the patient is a safeguard against all complications, or the eventual need of surgical assistance, which however, if the diagnosis is made too late for medical treatment alone, can in combination with it, prevent degenerative changes.

Owing to the indefiniteness in diagnosis of abdominal pathologies, the frequency of diverticula is of comparatively recent recognition. In reviewing the literature on the subject one finds that only in the last fifteen years has there been widespread interest in this subject and many valuable articles based on extensive experience are available. (See compended bibliography.)

HISTORY: Cruveilhier in 1849 was the first to recognize colonic diverticulitis as a disease. It was described by Verchow in 1853. In 1858 Sydney Jones reported to the Pathological Society of London a severe case of diverticulitis which caused a fistula between the urinary bladder and the pelvic portion of the colon. The first case, however, reported as operated on after proper radiological study was in 1914 by Robert Abbe, Lewald of New York being the roentgenologist. When the study of gastro-intestinal conditions by X-ray became general, attention was called to the frequency of diverticulosis becoming through inflammation diverticulitis, with the production of grave pathological processes in a certain type of patient between the ages of forty and sixty. The concensus of opinion, based on series of from 100 to 4500 radiological examinations, is that this condition is a definite clinical entity with welldefined sequelae, twice as frequent in men as in women, and that one person in eight with abdominal symptoms which vary from those so slight that they may be overlooked to those associated with profound disturbance, have colonic diverticula. Occasionally they occur in thin persons but tall, asthenic patients rarely have diverticula which may be one reason for the greater longevity of that type of "frail" person.

ETIOLOGY: Among the predisposing causes, it is possible that primarily the distributions and angulation of the colon play a part, as influenced not only by acquired ptosis, but by the congenital position of the spinal column through helping to

produce a flabby pendulous abdomen containing a relaxed colon. Dr. Agnes Vietor of Boston found in a series of studies made on still-born and premature infants in the Sloan Maternity Hospital in New York, in the New York Infirmary for Women and Children, and in other hospitals, that malpositions of the viscera exist even in infants whose inter-uterine life has been spent with the force of gravity acting in the direction opposite to that commonly credited with being a cause of ptosis. She traces this paradox to the lines in which the mesenteric and other peritoneal folds are related to the bony frame, as influencing the circulation and enervation in the colonic tissue and the resultant faulty nutrition thereof. It is well to keep the position of the spine diagnostically in mind whether we conclude that diverticula are congenital or acquired, for the average adult acquires a faulty posture between the ages of forty and sixty.

LOCATION: Diverticula of various sizes may arise in any part of the alimentary canal from the esophagus to the rectum but 70 per cent to 80 per cent are on the descending colon and the sigmoid. Their relation to the circumference of the bowel is practically constant for they are rarely found except between the mesocolic and antimesenteric longitudinal muscular bands closer to the latter. The colon has a weak internal circular muscular coat and the longitudinal layer is composed only of three weak bands which in the sigmoid become scattered longitudinal fibres. Owing to this, the colon is not able to exert or withstand much pressure; it is intended that the contents should be soft. If more than 80 per cent of water is absorbed, it cannot unaided expel its contents and the voluntary abdominal muscles are called in to assist; the weak musculature of the colon gives way and the mucous membrane is gradually forced through the weakest points. This is why diverticula occur most frequently in the sigmoid where the greatest force is exerted by the contraction of the abdominal muscles and the diaphragm when constipation exists.

CAUSE: In middle age there is a lowered plane of metabolism and imperfect oxygenation of the tissues. Loss of elasticity of muscle is not confined to striated muscle but affects the unstriated muscle throughout the body including that of the intestine. The weakening of the muscular coat of the colon is increased by infiltration of fat. These factors together with an increase in intracolonic pressure from constipation, straining or

gas, cause the mucous and submucous coats of the bowel to protrude through the muscularis, most often at the points where the muscular coat is penetrated by the left colic, and the sigmoid branches of the inferior mesenteric blood vessels. There is a theory that conditions which slow the blood return from the colon, as cirrhosis of the liver, predispose to diverticula by stretching the apertures through which the varicosed vessels pass but diverticula are too general for this to be accepted as a frequent cause.

Types: There are two, the "true" which are small pouches of all the coats of the colon, and the "false or incomplete" which are hernia of the mucous membrane only. The majority when diagnosed have reached the so-called "false" type of sac. Sometimes they are obscured by being located in the appendices epiploica or in the fat of the mesenteric border. The diverticula which sometimes occur in the ascending and transverse section of the colon rarely become inflamed, as the bowel contents there are liquid, whereas, in the descending colon and sigmoid the contents are usually solid. The functions of the colon are: (1) the conduction of food residue and of material added in the colon, (2) the gradual absorption of water in the ascending and transverse portions, (3) secretion of mucin for lubrication and destruction of bacteria, (4) excretion of lime, magnesium, iron, and mercury.

The forward movement of its contents to the splenic flexure is due principally to the segmental contractions of the bowel which when there is constipation force fecal matter into the diverticula; their narrow orifices and lack of a muscular coat prevent its expulsion; the fecal matter becomes moulded to the shape of the diverticular cavity and forms a concretion which at times becomes so adherent that the mucosa is stripped off by the attempt to remove the concretion. The contents of the diverticula vary in consistency from fecoliths to chalk or pus. The mucosa may be healthy, atrophic, ulcerated or cicatrized.

SYMPTOMS: Mild cases, until secondary complications arise, have few symptoms except (1) a vague abdominal discomfort which is relieved by a hot water bottle or lying on the left side, the abdomen relaxed and supported by a pillow; (2) a sense of heaviness increased by pressure which also causes excessive eructation of gas, and a sensation akin to faintness; (3) frequent urination due to the relation of the sigmoid to the left ureter and to the bladder; (cystic irritability often calls

attention to the presence of diverticula); (4) abdominal discomfort and fatiguability increased by jolting in long automobile rides or exercise in a vibratory machine; (5) mild autointoxication, characterized by lassitude alone, or in severer cases by loss of memory, difficulty of concentration, insomnia, apprehension, dizziness and nausea.

Subacute cases of diverticular inflammation cause a temperature of 99-100° F., increasing tendency to constipation, distention, spasmodic pain increasing in severity for several hours in the left lower quadrant of the abdomen, referred in some cases to the perineum or groin. If the patient remains in bed on a liquid diet and saline cathartics are given, he usually feels better after a week than for some time previous to the attack, on account of the elimination of the toxemia chronically due to absorption.

Severe attacks are characterized by tenderness along the descending colon, spasticity and tenderness of the sigmoid, pain referred to the left iliac fossa during or following evacuation, intermittent or persistent pyrexia, painful micturition (if there are vesical adhesions). Mucous and some blood, or pus, may appear in the stools after a paroxysm of pain. Parasites are not present and in chronic cases the stomach contents sometime show a decrease in hydrochloric acid. Blood findings in cases of several years standing are usually those of secondary anemia with leukocytosis; in the urine a trace of albumen and a few pus cells; no blood or casts. Inflammation may be mild and subside, severe and perforate, or may cut off the blood supply and cause gangrene of the fatty appendices epiploica, causing severe systemic intoxication. When subacute proliferative inflammation begins around a fecal filled diverticulum it progresses slowly, as granuloma form around a foreign body, with the added infection of the bacteria present in the lower bowel. The deposit of inflammation may involve the entire length of bowel in which the diverticula are situated or only surround one or two. It appears either as a thickening of the gut into a hard mass with gradually increasing stenosis from the chronic diverticulitis and the peridiverticulitis which produces increasing constipation and inflammation of mucous membrane, sufficient to cause partial or complete obstruction of the lumen. Round cell infiltration results in mass formation. The hyperplastic extra mucosal inflammation causes rigidity and a palpable tumor which may disappear and return in a

few days; the differential diagnosis is based on its being movable.

Gynecological symptoms vary with the relation of the sigmoid to the uterus and the degree of inflammation. Vaginal examination may discover a tender semi-solid mass in the posterior cul de sac not attached to the uterus, or a mass about the size of an orange may be found high in the pelvis according to the location of the portion of sigmoid affected. This between examining fingers is found to be tender on all sides. Sigmoidoscopy is unsatisfactory because the irritation causes resistance and the lumens close. The sigmoid may become adherent to surrounding structures and through contraction of adhesions produce obstruction or the chronic and diffuse thickening may be itself sufficient to cause obstruction, the symptoms of which are: distention, late vomiting, caecum palpable when in peristalsis. Constipation is usual but there may be alternating constipation and diarrhea or either alone. Diagnosis is assisted by a history of recurrent spasm and inflammation over a period of years. A spastic colon may be either the cause or the result. When stools are dry and small in calibre, an X-ray examination should be made at once. Acute infection simulating left-side appendicitis (the appendix is in fact a congenital diverticulum), ulceration and perforation may develop suddenly and cause pelvic or general peritonitis.

DIAGNOSIS: On the X-ray plate diverticula appear as small, round or oval shadows, or luminous spots, outside the bowel but connected with it. They are easily seen unless they overlie the lumen; then, however, by turning the patient to right and left oblique positions they can be brought into profile. If spasticity and other symptoms indicate diverticula, do not abandon the search until X-ray pictures, following manipulation of the colon, have been taken in all possible positions. They may be sessile, pedunculated, with smooth or ragged edges according to whether or not ulceration has taken place.

X-RAY: The diverticula remain filled with the barium from twenty-four to forty-eight hours after the rest of the colon is empty.

To Dr. Judson Quimby of New York I am indebted for the remarkably clear demonstration of the presence of diverticuli in cases where they would, by a less expert roentgenologist, be overlooked, also for the generous interest he has shown in the yearly study of cases under my treatment.

Dr. W. H. Rowden, in the British Medical Journal of March 1, 1930, calls attention to the earliest change in the appearance of the bowel in diverticulitis as an alteration in the haustra. Instead of presenting the normal appearance of a regular outline of the segmentations with indentations opposite to each other, the indentations in the stage of irritation not only alternate but smaller ones appear. In the next stage the indentations in addition to being spaced irregularly become irregular in outline, producing a V shape in the bowel as a whole. This is the stage of thickening. When the condition is more advanced there is a filling defect caused by the encroachment on the lumen by the thickened wall. The three stages can sometimes be seen in different parts of the same bowel. In ulcerative colitis there is a complete loss of haustration.

The point which I wish to stress in this paper is the importance of making a search for diverticula a routine phase of all gastro-intestinal study. When this is done, many cases which would escape notice until serious symptoms develop are diagnosed and sequelae prevented. If routine search is made for diverticula they are so easy to discover and yield to treatment so satisfactorily they may be put in the preventive medicine category, after a complete physical examination to determine the necessary care of other organs.

In the October, 1929, issue of the Journal of the Florida Medical Association, Dr. John A. Herring of St. Petersburg states that he prefers the enema method to the barium meal. I have found the combination gives results clearer to me, and more educational to my patients, when there are no symptoms of obstruction. Dr. Herring points out that the advantages of the enema skillfully given are: it takes only a few minutes and the plates can be read almost immediately; if any obstruction is encountered, the enema can be immediately stopped as the entire colon can be under observation during its administration. I have found, however, a disadvantage in the pain caused when there are adhesions and also through increase of tension, as well as acute and persistent eructations in supersensitive patients. The diverticula show as readily after a barium meal when the bowel has had a preparatory cleansing. In cases of stasis diverticula have remained demonstrable for forty days through their barium content. When they are not clear, it is advisable twenty-four hours after the first barium meal to give another, also a barium enema and wait twenty-four hours longer

for a second series of films. If the results are not entirely satisfactory then wait a few days and reprepare the bowel by aperients and low irrigation. The diverticula show best forty-eight hours after a barium meal and twenty-four hours after a barium enema, for then the barium from the lumen of the gut has been evacuated. If the diverticula are not clearly demonstrable, repeated enema will be necessary before barium will enter the small mouths of the diverticula for they are covered by proliferating mucous membrane, so inflammation must subside to some degree first. Also, they may not show because they are filled with hard feces which however become softened by preparatory treatment.

The rapid passage of an opaque meal to the sigmoid indicates an irritable condition of the bowel. When duodenal ulcer causes a premature emptying of the stomach, the food, owing to its early arrival, remains longer than normally in the ascending and transverse colons. More water is therefore absorbed, which accounts for constipation being associated with duodenal ulcer. Differential diagnosis is, however, easily made by X-ray.

Size: After the bulk of the barium is evacuated, small opaque areas may be seen varying in number from one to three hundred or more, and in size from one-fourth of an inch to six inches or larger according to the internal distention and the amount of inflamed peri-diverticular proliferation. The appearance of the diverticula depends on their location and the amount of inflammatory deposit along the mesocolic attachment. Inflammation is favored by the thick deposit of fat under the serous coat and in the appendices epiploica in obese persons. If inflamed they may be buried in a hard mass of new formed tissue. When small, not filled, or inflamed the diverticulum shows microscopically the structure of the colon. When distended by fecal contents or altered by infection, the mucous membrane is flattened and the muscle attenuated or absent. Cases are reported in which the diverticulum with its fecolithic contents may sever itself from the bowel and become a free body in the peritoneal cavity. In partial obstruction X-ray after a barium meal reveals a narrowing of the lumen of the gut for two or three inches in the inflamed and spasmodic area, or may show no barium although the colon above and below is Fecaliths, calcified glands and urinary calculi must be excluded from the X-ray diagnosis.

TREATMENT: Mild cases require a restricted diet which patients willingly accept because they realize the common sense of keeping away from danger and after a few days feel greatly improved in health. Abdominal discomfort and the tendency to biliousness and headache are relieved by clearing the concretions. The general tone of the patient improves after the first week, the definite diagnosis and the expectation of cure have a tonic psychological effect.

Vegetables, brown bread, extremely well masticated, oatmeal porridge, only one starch at a meal and that liquified in the mouth by thorough chewing are recommended; a general vegetable diet, orange or grapefruit in the morning and a strict limitation of proteids. Cherries and other fruits with skins, figs, blackberries, gooseberries, strawberries, raspberries, currants, and other small seeded fruits should be forbidden. I have found useful the climination of eggs, butter and cream.

In mild cases, that is, where there are no more than six diverticuli, only two months' treatment is necessary to effect a cure; other cases in proportion. I have found the best treatment is two heaping tablespoons full of barium sulphate dissolved in a glass of water and taken in the morning on an empty stomach twice a week, followed twenty-four hours later with one and one-half tablespoons of mineral oil and agar. For obese patients I prescribe thirty-six hours later Epsom salts two-thirds; sodium one-third; one oz. one-fourth of an hour before breakfast.

Spasm of the colon and irritation of the diverticula may be prevented by food which leaves a bulky colonic residue which is kept semi-liquid by the use of liquid paraffin sufficient to produce two loose movements a day. Colonic irrigations are beneficial when they do not cause discomfort. The best results are obtained when they are given on two succeeding days and omitted for three. Otherwise I prescribe small injections of warm water, or injection of hot gelatine, eight ounces of 10 per cent solution at 120° placed in the sigmoid. After the acute stage a definite line of dietic and colonic hygiene should be continued indefinitely. During an attack, the patient must remain in bed, diet should be liquid and colon contents kept liquid with salines. In severe attacks, antispasmodics, luminol or atropin may be required. Oversight of general systemic conditions is obligatory for double pathology should always be kept in mind. In neglected cases abscess formation is usually on the left side of the pelvis, in the iliac fossa or in

the Douglas pouch although the mobility and length of the sigmoid may produce right sided symptoms.

Surgical treatment requires careful judgment and is indicated only after sequelae have developed. The once popular short circuit operation for removing diverticula is not justifiable because the condition can be cured by less drastic measures and excision of the colon in obese patients is dangerous. The histological and pathological conditions leading to diverticulitis are common throughout the colon. They are usually widely distributed and others may appear in a contiguous location after the removal of those that are inflamed. This over-popular operation made in its early days a dramatic appeal because it seemed remarkable that a person could live after several feet of colon had been removed, but the end results were seldom satisfactory and the surgeon's first duty is to consider the continuation of the patient's life rather than the brilliancy of an operation.

Excision and suture or drainage of an abscess may be all that is necessary or all that can be done. Fistula should be closed by appropriate methods before the colonic problem is taken up. When resection is inevitable it should be preceded by a colostomy to relieve the inflammatory process before that is handled. Patients may collapse rapidly from the severity of the toxemia. They are unable to stand a prolonged operation. Gasoxygen and local anesthesia are best. A colostomy should be made above the site of the perforation.

After operation it is difficult to prevent a temporary fistula. It is, therefore, best to drain rather than close the wound and to allow for this by making transverse or oblique incision through the abdominal muscles. If resection of the colon is necessary, a decision must be made between a transverse colostomy, a side opening or a short circuit. Mekulicz resection is considered the best. After drainage of the colon above the mass, the lumen of the bowel at the site of obstruction tends gradually to be restored and a vesico-colic or other fistula will close when free of infection and irritation, so it becomes possible later to close the colostomy. This may take as long as three years and can be decided by X-ray examination.

The relation of diverticulitis to carcinoma is our chief concern today. As carcinoma usually comes from prolonged irritation and scar tissue, it seemed justifiable to devote some time to a consideration of prevention. Malignancy does not usually cause loss of weight until there are sccondary deposits, and it is too late for operative benefit. In 1917 W. J. Mayo reported forty-two cases of diverticulitis in thirteen of which there was carcinoma. He insists that chronic diverticulitis should be regarded as a pre-cancerous condition. Some authors report 14 per cent in which malignancy develops. Judd and Pollock have drawn attention to the point that 15 per cent of their diverticulitis cases had blood in the stools while 65 per cent of the malignant cases showed blood. Carrington Williams of Richmond states in the Virginia Medical Monthly in May, 1924, that 30 per cent of cases of diverticulitis with mass formation have cancer in addition to the inflammatory process.

In conclusion the following points are suggestive: (1) carcinoma is frequently in the same region; (2) diverticulitis is often mistaken for other things and so has not been associated with the diagnosis of carcinoma; (3) the recognized development of carcinoma on a gastric ulcer scar; the histological identity of colonic and gastric mucous membrane; (4) the tendency of diverticulosis to become diverticulitis and end in acute or chronic ulceration; (5) post-mortem carcinoma and diverticula are often found on different areas of the same section of colon; (6) where the diverticula have degenerated the carcinoma has developed. The prevention of a definite percentage of carcinoma is obviously in the early diagnosis and medical treatment of diverticula; or failing that in the conservative operative measure of draining single or multiple abscesses, giving the colon time to recover its tone by removing irritation through establishing a temporary colostomy, and if diagnosis is made after diverticulitis is advanced to avoid trauma to inflamed tissue and operate conservatively.

DIFFERENTIAL DIAGNOSIS

Diverticulitis

- (1) Freely movable.
- (2) Rectal examination is usually negative because the entrances to the diverticula are generally small and the friction irritation of the proctoscope causes them to contract, or a mucous fold may obscure them.
- (3) Inflamed folds of otherwise normal mucous membrane appear as obstruction.
- (4) Acute, chronic or recurrent cystitis, infected tonsils, sinuses, subacute arthritis, endocardi-

tis, and other conditions caused by continuous subacute infection present.

- (5) Length of bowel involved
- (6) Diverticula in neighborhood
- (7) Typical V deformity
- (8) Spasticity

Carcinoma

papillmatus

- (1) Not freely movable
- (2) Mass and thickening are observable
- (3) Degenerated tissue
- (4) Not found
- (5) Short
- (6) Maybe none(7) According to typeadeno-care ulcerative adeno-carcinoma
- (8) Spasticity l encircling ring

Immovable mass, cachexia, loss of weight, following long continued symptoms of diverticulitis indicate its changing to carcinoma. Patients sometimes give a history of feeling better than for years on the termination of symptom of pus absorption, so even when carcinoma has developed the medical treatment of diverticulitis is beneficial. General fatigue, increasing weakness and the presence of occasional blood streaking the stools typify progressing carcinoma. My advice in such cases is usually against operation, as it does not seem fair to submit patients and their families to the shock, pain and expense incident to fostering a false, even if momentarily stimulating hope, for statistics give no encouragement regarding the late removal of carcinoma. This causes me to emphasize the extreme importance of routine search for diverticula in all patients with abdominal or absorption symptoms, with the assurance that in Florida we can find both expert and patient roentgenological cooperation.

The following cases and X-rays demonstrate the paper and also occasional divergence from the typical symptoms.

Case 1: Woman, sixty years of age, flabby abdomen, generally relaxed tissues, nervous irritability and indecision, a diffuse mind which made it difficult to secure the necessary X-ray pictures. In two and one-half months the X-ray pictures showed a disappearance of the diverticuli; she was entirely well and potentially ten years younger.

Case 2: Woman, fifty-four years of age, who had been very energetic and was depressed by her

sudden lack of ability and tone; and a family history of carcinoma of the stomach. She was greatly relieved on finding that the stomach was normal and that she had three colonic diverticuli. She continued her work with increasing capacity during above routine treatment; X-ray pictures showed a cure at the end of three months. Probably this would have been hastened if her work had not necessitated frequent accumulation of fatigue.

CASE 3: Woman, fifty years of age. Vague symptoms, much abdominal tenderness and gas, extreme discomfort on using vibrator machine for weight reduction and sudden semi-collapse after exercise with arms raised in the vibrator, due to the rupture of one of the diverticuli; the scar and the ragged edges of the tissue were apparent in the first X-ray pictures taken.

Case 4: Woman, fifty-six years of age, short, stout and intense, transitory neuritis in both arms, chronic nephritis. X-ray shows large ulcerated diverticuli. Showed improvement in one week's treatment. Cured in six weeks. Urinalysis report showed marked improvement in renal condition.

CASE 5: Man, forty years of age. Multiple diverticuli of the colon. First symptoms that of prolonged hemorrhage from the colon with exsanguination. Hemorrhage from ulcerating diverticuli.

CASE 6: Woman, forty-five years of age. Case having spastic colon with extreme autointoxication. Evidence of ulceration of the sigmoid which probably consisted of ulceration of diverticuli at point marked.

Case 7: Man, forty-seven years of age. Spastic colon with prolonged stasis, multiple diverticuli. Note large diverticulum on the left transverse colon containing a vacuole which represents a transparent enterolith.

CASE 8: Woman, fifty-seven years of age. Case of chronic arthritis with very spastic colon, pylorospasm and multiple diverticuli of the colon. Note very large number of diverticuli on the sigmoid. Diverticula are most numerous on this section of the bowel in the majority of cases. It is also observed that the sigmoid is evidently bound down in the pelvis by adhesions, probably secondary to chronic diverticulitis.

CASE 9: Man, sixty years of age. Diverticula are very large, most numerous on the lower end of the descending colon and sigmoid. Case suffering from pylorospasm. Spastic colon and autointoxication. Chronic diverticulitis has established adhesions of the sigmoid.

To Dr. A. W. Sherrill of Pittsburgh I am indebted for the report on the following unusual case:

W.R.: Age 71.

For last eighteen months, patient has had frequently involuntary movements of bowels, at times passing a good deal of blood mixed with stools. Was seen by several physicians in the East who persisted in giving him bismuth and astringents. When first seen had a profuse diarrhea, involuntary movements, incontinence of urine, abdomen greatly distended, was toxic, extremely nervous and mentally depressed; vomiting large amounts of foul, partly digested material. A large mass irregular in outline, apparently not attached to surrounding tissues, was easily felt in upper left quadrant of abdomen. The mass persisted after high irrigations and laxatives. At times stool contained blood and tissue which proved to be necrotic tissue from colon and sigmoid.

URINE —High specific gravity; few granular and hyalin casts; occasional R.B.C.; few pus cells; out-put decreased.

BLOOD—R.B.C. 3,200,000. W.B.C. 8,000 to 10,000. Differential count of no moment. Hemoglobin 70%.

Blood and spinal fluid Wassermanns negative. Reflexes all lessened but otherwise normal. Argyle—Robinson pupil. No sensory changes.

Because of his age, emaciation, distention of abdomen, toxic condition, blood in stool, with pressure of mass, carcinoma was thought the most likely condition.

After repeated attempts in giving barium enemas, a picture was obtained which showed numerous diverticuli of sigmoid. The patient improved rapidly when treatment was instituted to relieve this condition. The undoubted cause of diverticulitis in this case is cerebral arterio-sclerosis, as it is manifested clinically. There being no evidence of syphilis and no sensory changes being present, and existing incontinence of urine, with no other determined cause further bears out this belief.

The cerebral arterio-sclerosis has affected this man in a rather peculiar way. He did not know

when his bowels acted, yet his sensory function is not impaired. The whole lower bowel had carried such quantities of material for long periods that pressure no doubt caused the diverticula, the diarrhea being simply softened material passing around the enormous masses of fecal material.

The bowel was distended to an enormous size and even after the bowel was well emptied the distention continued. The mental condition has cleared to a great extent, probably because he is less toxic. This case has been under observation for two years and has improved to a marked degree, except cerebral changes which have increased. The supposed cancer mass has disappeared and has never returned.

Dr. Quimby has kindly sent me the films on the four following cases with a report on each as follows:

No. 1: Hemorrhage of the bowel secondary to ulceration of diverticula. This case was brought in on two different occasions after having bled to almost exsanguination. In fact, the return from the enema given when this film was taken was pink with fresh blood. In each instance, the use of barium promptly stopped the hemorrhage.

No. 2: Is a typical case of diverticula of the sigmoid, some of which had undergone ulceration with the resulting deformity of diverticula. Constitutional reaction to an intestinal focus of infection was the predominant symptom in this case.

Nos. 3 and 4: Typify the residues seen in diverticula, 48 and 54 hours after the administration of a barium meal. In film No. 3 several diverticula in the left pelvis are very large. This case had adhesions in the left pelvis, the sequella of chronic diverticulitis.

No. 4: Had a great number of diverticula on the descending colon and sigmoid, as can be recognized. The diverticula contained transparent material coated with barium sulphate. The transparent part is retained feces.

Dr. Robert J. May, of Cleveland, Ohio, has kindly sent me a report:

Male, age 58, reported had good general health, had always been well, recently had loss of appetite, frequent belching, constipation, abdominal discomfort, no actual pain, no loss of weight, no history of abdominal operations.

X-ray showed that food remained too long in stomach; a number of prominent diverticula in pelvic colon and a narrowing of the bowel lumen in corresponding section.

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DISCUSSION

Dr. Harry A. Peyton, Jacksonville:

Diverticulosis of the colon is a fairly constant finding during routine X-ray study of this organ, occurring in about 6 per cent of individuals forty vears of age or beyond. Since most of these cases are studied because of some symptom with reference to the colon, the actual percentage of recurrence must be still lower than 6 per cent. Taking these figures as granted as to occurrence, the number of patients developing pathologic lesions, diverticulitis, etc., is again small. The most reliable statistics available, those from the Mayo Clinic, show 12 per cent incidence of diverticulitis. Other interesting details from this clinic show that of 1919 cases of diverticulosis, only sixteen were below forty years of age; also, that according to sex, there were 64 per cent males and 36 per cent females. The latter figures would tend to repute the theory that constipation is a pronounced factor in the causation of diverticulosis.

The relationship of diverticulitis to cancer is difficult of positive proof, but must be likewise rare, as at the Mayo Clinic in 227 cases reviewed, carcinoma was found in only four instances. The actual diagnosis, while difficult, may be made from the history and X-ray findings.

The discovery of diverticulosis imposes definite obligations, as these patients should be made aware of the condition, given instructions as to diet, etc., and the dangers and possible complications explained.

Dr. W. C. Blake, Tampa:

I have enjoyed Dr. Morton's very interesting paper. Diverticulosis, of course, is a very common condition. The Mayo Clinic, taking its impression from various sources, has fairly well established the fact that fully one per cent of the population have diverticula in the colon. presence of diverticula as shown by the X-ray film certainly is not sufficient evidence to warrant the assumption that intestinal symptoms are due to their presence. Of course, a bottle-shaped diverticulum with improper emptying presents an ideal situation for the formation of an inflammatory process such as occurs in the appendix and diverticulitis must be considered in any acute abdominal condition. Dr. Friedenwald, speaking before the American College of Physicians, recently brought out this particular point and emphasized it. He advocated doing away with the small gridiron incision in favor of a larger incision that would permit a more general exploration.

Dr. Pottenger of California, who himself suffers from a large diverticulum of the sigmoid, has recently reported his own personal experience. His symptoms have ranged all the way from vague general abdominal discomfort to very severe colicky pains. Of particular interest is the manner in which the pain was referred from the sigmoid through the visceral nervous system to various parts of the body. The varying and bizarre symptomatology in his case shows that quite a diagnostic problem can be present.

The question of the relationship between carcinoma and diverticulitis is, of course, one which has not been definitely settled. We know that chronic irritation of any mucous membrane acts as an etiologic factor in malignancy, but when the actual statistics on the subject are studied, there is found to be practically no relationship between the two. Rankin and Brown have reported nearly two hundred fifty cases of diverticulitis which required operation and in only four was a coexisting carcinoma found. On the other hand in nearly seven hundred cases of carcinoma of the bowel which came to operation, the presence of diverticulosis was noted in only four. It would appear therefore that the relationship between the two conditions in more casual than significant.

As to surgery: Diverticulitis usually presents chronic symptoms over a long period of time with occasional acute exacerbations. These symptoms will usually respond to medical treatment and surgery should be reserved for the more severe cases and for complications which occasionally take place.

Dr. Rosalie Slaughter Morton, Winter Park (concluding):

The points brought out by Dr. Peyton and by Dr. Blake are extremely interesting and I appreciate their courtesy in discussing my paper. I have nothing to add at this time, except to reiterate my opinion that all patients who have abdominal symptoms or reflex symptoms, which may be associated with auto-intoxication, should have a routine X-ray examination for diverticula, both for accuracy of diagnosis and treatment, and also to prevent, if it is only one in five hundred, the development of carcinoma.

SOME OBSERVATIONS ON HYDRO-CHLORIC ACID AS A FACTOR IN GASTRIC SURGERY* Marvin Smith, M.D.,

Miami.

In the embryo the stomach appears as a lateral flattened fusiform enlargement of the foregut; it begins to descend and forms the gullet, etc., hence the stomach occupies the position between the termination of the esophagus and the beginning of the small intestine.

The outlines of the normal stomach are very changeable, but for working purposes it seems practical to select the notch incisura angularis on the lesser curvature as a starting point from which the stomach may be divided into two main portions, the cardiac and pyloric. The chief digestive acid substances are secreted by the cardiac portion while the pyloric division secretes alkaline substances.

The principal constituents of gastric juice are pepsin and rennin and the organic acids, butvric and acetic and the mineral acid, hydrochloric, the latter having been found in the stomach first by Schmidt in 1847. The existence of hydrochloric acid in the stomach is interesting because it is found nowhere else in the body in the free state. Formerly it was believed that no gastric juice was produced except at eating time and that the glands were excited to activity by the presence of food only, but it is definitely known now that the secretion is constantly going on but is increased during the active stage of digestion. It is believed that some chemical element in the food excites the glands since inert substances do not stimulate the glands to secretion.

There is variation in the percentage of hydrochloric acid in the gastric juice secreted during the digestion of a single meal consisting of bread, meat, vegetable, milk and dessert; after such a meal it would run for the first hour about 200 cc., second hour, 150 cc. and third hour 350 cc., a total of 700 cc. or about two quarts per day. Kind of foods and other factors influence the amount of the flow, for example fats and oils prevent the flow for some time and also retard the motor power of the stomach while they increase the speed in the small bowels. Carlson claims that the intravenous injection of the watery extracts of strawberry, lettuce and spinach will increase the secretion. It is believed that histamine, gastrin and pilocarpin will do the same thing.

*Read before the Staff meeting of Victoria Hospital, Miami, June 19, 1931.

Since hydrochloric acid in the stomach must be looked upon as having distinct antiseptic power it at once becomes our main sheet anchor of protection against invasions in the stomach and small bowel against bacterial infection which is constantly being taken in on foods; however, it is now believed by some that in the upper portion of the small gut, there is some protection afforded in surgery by certain types of colon bacilli.

For simple practical purposes, then, it is well to classify the different types of stomach secretions into hypo-acidity or achylia gastrica and hyperacidity or hyper-secretion.

In this brief survey I have presented to you merely as a review the current beliefs of numerous authors and now without going further into exhaustive detail in this short paper, suffice it to say that there are many factors such as improper foods, alcoholics, cancer, pellagra, beri-beri, etc., that induce achlorhydria or achylia-gastrica. Apparently the condition is brought about by injury to the gastric glands rather than to the nervous control.

The hypersecretive stomach is one in which the secretory response to food is prolonged; many believe that no known disease produces hyperacidity though hyper-secretion is often recognized in appendicitis and intestinal adhesions, kinks in the colon, ulcers in the sigmoid and early gall-bladder disease. Reischmann's disease or essential hypersecretion is said by some not to exist.

Ulcers of the stomach or duodenum may exist without pyloric obstruction and the gastric juice be at the upper limit of normal or at any point between this and complete achylia.

Koch, Falk, Macfadyen and Bassler positively declare that the hydrochloric acid in gastric juice is antizymotic and antiseptic because it prevents abnormal fermentation and destroys pathogenic organisms; as previously stated then it is obvious that this is a safeguard to the economy from infection.

With apologies, I wish now to mention a few points that I have observed in doing surgical operations on the stomach in this hospital in the last two years. Invariably, I have been able to obtain gastric analysis on every case so treated and with only a few exceptions I have had the opportunity to plan a little preparation of the patient before instituting surgical treatment.

In the pyloric stenosis cases of the hypersecretion type, I have practiced lavage for two or three days, prior to operation, using soda solution with liquor antisepticus alkalinus. In the pyloric stenosis cases of the hypoacidity type I have lavaged with normal salt solution and liquor antisepticus and have also administered hydrochloric dilutum three times a day for two or three days.

In gastric and duodenal ulcers which I have treated by excision, no preparatory agents were used except 30 grains of bicarbonate of soda by mouth for twenty-four hours before to combat acidosis—no lavage was done since no gastric ulcer has yet been reported where hydrochloric acid was not present and but few duodenal ulcers. These patients were given rest in bed, vegetable and animal broth for twenty-four hours and soda by mouth as above stated.

I recall one case of a woman about 65 with achylia gastrica and an obstructing benign pyloric tumor in which I did a pylorectomy and Billroth II operation which was followed by a very persistent and troublesome wound infection which lasted two weeks or more before it cleared up. The patient vomited so frequently before operation that my efforts to administer hydrochloric into the stomach were defeated and then I reasoned that the reversed peristalsis brought an extra supply of bacterial life from deeper down in the jejunum, so I felt that the prolonged convalescence was due chiefly to the absence of hydrochloric and to my inability to aseptisize the stomach beforehand

Also in this series of cases was a sleeve resection of the stomach for hour-glass contraction. This was a hypersecretion case and although the usual amount of soiling of the operative field was present, yet the wound closed by first intention

I wish to now mention one or two points in the handling of a patient which I recently dismissed from the hospital: Mrs. M., age 48, complained of severe headaches, nausea, vomiting, anorexia, loss of weight and gradual abdominal enlargement. Patient was weak and nervous-no bowel movement for five days. At my own laboratory we passed a small stomach tube and withdrew contents which showed upon analysis, no free hydrochloric but 90° of total acidity. An opaque meal in the stomach showed it to be greatly enlarged, with complete stenosis of the pylorus. In the hospital, effort was made to clear out the stomach before operation, but on account of the choking of the tube with food particles and considering the enormous quantity of food material in it, this was a failure.

Usual incision for gastro-enterostomy was made; the stomach was found to be, of very large

size, occupying the entire lower and most of the upper portion of the abdominal cavity. It was filled with pork chops, lamb stew, bread, vegetables, potatoes, etc., most of which had been in the stomach for days. During the clearing out on the operating table, despite all efforts to avoid it, there was general soiling of the entire operative field and viscera in the epigastrium. Nevertheless, the wound closed by first intention and the patient made a rapid, uneventful recovery. Without doubt the high degree of total acidity in the stomach contents saved the patient's life; it not only had destroyed all harmful bacteria in the stomach contents, but as soon as the operation was over free hydrochloric was produced in amounts sufficient to continue the protection against bacterial invasion; most of the acid found was in the combined state.

Fortunately, alkalosis with its chain of tetanic symptoms had not set in.

A year and a half ago I operated upon a middle-aged woman in this hospital who had been bedridden for a year or two. A rather unsatisfactory work-out was done on her but the findings showed an achylia gastrica stomach which required eighteen hours to empty. I believed that I had made reasonable effort to combat the alkalosis before the operation for the stenosis. The patient, however, died in about 30 hours from what I then thought was atypical surgical shock, but I now feel convinced that her death was from alkalosis and renal insufficiency and that I had not pushed my preparation quite far enough to bring up her blood chlorides.

For the past eighteen or twenty months I have as far as possible and feasible paid close attention to the gastric chemistry in my cases of stomach surgery. In fifty-six cases including gastric and duodenal ulcer, hour-glass contraction, pyloric stenosis from cicatricial contraction, obstruction by malignant and benign tumors of the pylorus, there were numerous wound infections which invariably occurred in the achylia gastrica cases while almost without exception those cases in which hydrochloric acid was present either as free, or combined, closed by first intention. All wounds finally cleared up.

The fact that no ulcer has so far been reported where hydrochloric acid was not present in the stomach is quite a satisfactory explanation as to why a large percentage of perforation cases recover. I feel, therefore, that its presence is a safeguard against infection wherever stomach surgery must be resorted to.

EXAMINATION OF THE URINE* JOHN A. PINES, M. D.

Orlando.

It is with reticence and almost a feeling of presumption that I come before this assembly of intellectual lights with this humble subject—The Examination of the Urine. Nevertheless, experience has convinced me that this test is very much neglected. To my mind, this is the most important laboratory test made and is the best means we have in helping to keep close check on a patient's condition.

There is hardly a disease, either acute or chronic, that does not in some way affect the kidneys at some time during the course of the disease. Every patient should have a thorough examination, including a urine analysis, before treatment is begun.

All of you physicians are competent to make this test, but many are too busy. We leave it to the office girl to test for albumen and sugar. If these elements are not found, we feel sure there is no serious kidney trouble and let it pass at that.

Many of you, I know, are more particular and have the urine examined in every detail, not only once, but many times. Patients seriously ill should have this examination every day. It will give you more valuable information about your patient's condition than any other test.

We have all met physicians who never ask for consultation and who seldom, if ever, send specimens of any of the body fluids or excreta to the laboratory for examination. The more progressive physicians either have a technician of their own or send their specimens to some reliable laboratory for examination. These are the men who get results and develop a large practice. Their patients are satisfied and stay with them and refer their friends also. Those who neglect or unfortunately do not see the necessity of using the laboratory soon lose out and are brushed aside by the wideawake progressive men.

In the brief time I have this evening I will not attempt to cover every detail of this test. I will limit my remarks to the consideration of what, in my opinion, are the essentials. A detailed discussion of this one test would require more than my allotted time to do it justice. Neither will I attempt to tell you many new things, but want to refresh your memory on the essentials of this test. Hardly a week goes by that some new test

^{*}Read before the Florida Midland Medical Society, Bradenton, Oct. 28, 1931.

is not given in our medical journals. Some of these are good and useful and simplify our work, others are too complicated and not practical for routine work.

I believe we should have a simple routine examination method, and time should be taken to make a thorough test, including a microscopic examination. Here are the things I consider most important in every urine test.

I The amount

11 The gross appearance

III The specific gravity

IV The reaction

V Albumen

VI Sugar or glucose

VII Microscopical examination.

I. The Amount. A 24-hour specimen should be obtained if possible, as there is quite a variation in the amount, specific gravity, reaction and total solids excreted at different times of the day. It is also important to know whether the specimen was voided or obtained by catherization. The daily volume of urine excreted by a healthy adult under average conditions is 1,200 c.c. for a man and 1,000 c.c for a woman. The amount is increased normally by an abundant ingestion of fluids or by cold weather.

The amount is increased pathologically by chronic nephritis, true contracted kidney convulsions (especially hysteria), diabetes mellitus, diabetes insipidus, cardiac hypertrophy, absorption of edema, resorption of large peritoneal or plural effusions.

The amount is decreased normally by a diminished ingestion of fluids or by profuse perspiration (hot weather). The amount is decreased pathologically by diarrhea, vomiting, lead poisoning, acute nephritis (sometimes chronic nephritis), diseases of the heart and lungs leading to passive congestion, febrile disturbances, shock after operation and low blood pressure.

II. The Gross Appearance of the Urine. The color, transparency, clear, cloudy, turbid or bloody, the presence of shreds or floaters—these should all be noted. Much valuable information can be obtained at a glance, but your investigation should go farther to determine what elements are present and what relation they have to your patient's condition.

The color is influenced by diet, drugs, bile or possibly blood which might be due to a normal menstrual flow and would mean nothing. A cloudy or turbid urine might be pathological, but more often is due to phosphates, urates or the products of bacterial action, or to an alkaline urine. Shreds or floaters are found following an attack of urethritis usually of gonorrheal origin. Bile gives the urine an orange or brown color.

III. Specific Gravity. This is a pretty accurate indication of the amount of solids excreted in the urine. Normal specific gravity is 1,015 to 1,025. A urine of high specific gravity is called concentrated. Urea is mainly responsible for the specific gravity if sugar is not present in the urine.

In nephritis a decrease in specific gravity without a change in the volume of urine indicates that the urea is not being excreted and that uremia may be feared. An occasional urea test should be made in these cases to keep check on the amount of urea being excreted. Normal urine contains up to 4 per cent of urea. The average amount excreted in 24 hours for a man on a mixed diet is about 33 grams, varying between 24 and 40 grams. A urea test is of very little value unless you know the amount in calories and the kind of food the patient has eaten in the 24 hours preceding the test. There are many people in perfect health who never pass more than 20 to 25 grams. the other hand, in diabetes, for instance, an elimination of 100 to 150 grams can scarcely be considered an evidence of disturbed nitrogenous metabolism, if it is borne in mind that they generally consume a much larger quantity of nitrogenous foodstuffs as a part of their diabetic treatment.

IV. Reaction. The normal reaction of a 24-hour specimen of urine is acid, due to acid salts, especially the acid sodium phosphate. During digestion the secretion of hydrochloric acid by the stomach diminishes the acidity of the urine, which may even become alkaline at this time. The more hydrochloric acid secreted by the stomach the more decidedly alkaline the urine simultaneously excreted. The bases which are freed at the same time remain to increase the alkalinity of the blood. Part of them pass into the urine, producing the "alkaline tide," which is often noted at this time. The acidity again increases during the process of resorption, which is known as the "acid tide."

V. Albumen. The presence of albumen in the urine is known as albuminuria. Although it may not necessarily mean serious organic disturbance of the kidneys, still it always points to some uri-

nary or systemic disorder, and its presence, however slight, demands consideration.

"True or renal" albuminuria is due to degenerative changes in the kidneys and is usually accompanied by epithelium from the tubules, often in the form of cylinders or casts.

"False or infra-renal" albuminuria. Changes in the composition of the blood or in the blood pressure may allow albumen to pass through the kidneys. This is seen in anemic conditions, after some poisons, and in some infectious diseases, the kidneys in any of these cases not being necessarily in a pathological state.

Albumen is found in the urine in acute nephritis (sometimes 2 per cent or over, though not usually more than 1 per cent), chronic nephritis or Bright's disease, acute infectious fevers, blood changes or abnormal substances in the circulation, disturbances of circulation (high blood pressure), nervous conditions and head injuries, inflammations of the urinary tract, and during pregnancy or parturition.

Many methods are given, but I consider the heat and acetic test the best and most practical. This consists in filling a test tube two-thirds full of urine and heating the top portion over a flame. If a white cloud is produced a few drops of 3 per cent acetic acid should be added. If the cloud disappears it was due to earthy phosphates and is not pathological; if the cloud remains or is intensified by the addition of acid it is due to albumen. The test should be viewed under a good light and against a black background. If a heavy cloud is produced a quantative test should be made.

VI. Sugar or Glucose. Traces of sugar may be found in the urine under strictly normal conditions. With the usual clinical tests normal urine is apparently free from sugar unless unduly large amounts have recently been ingested. In that event a certain amount of sugar is eliminated in the urine constituting the so-called "digestive glycosuria."

A transitory glycosuria is occasionally observed in acute febrile diseases, such as typhoid fever, diphtheria, influenza and especially malaria during convalescence. A continuous elimination of sugar is noted principally in diabetes mellitus.

Many tests have been given for the detection of sugar in the urine. Fehling's test is accepted by most insurance companies. This is a simple, reliable test and the one I use in my laboratory. The

solutions should be mixed fresh each day, as they deteriorate on standing longer than 24 hours.

If a patient's urine shows sugar on several occasions a blood sugar test should be made to determine the amount in the blood stream. If this is high, above 120 millegrams per 100 c.c. of blood, the diet should be regulated and the patient's urine should be tested daily until it becomes sugar free.

In case sugar is found in a patient's urine it should also be tested for acetone and diacetic acid; otherwise it is unnecessary to make this test in a routine urine analysis.

Tests for bile, indican, certain poisons, the diazo reaction and many other tests are made on the urine in special cases where they are indicated, but these are not necessary in the routine examination.

VII. The Microscopical Examination. This is very important and should be made on every specimen analyzed. Often times a chemical examination may reveal nothing pathological. The microscope is more accurate. Pus and blood cells or a few casts may be found which would not be sufficient to produce an albumen test.

Some clinicians prefer to examine a drop of the uncentrifuged urine, while others centrifuge the specimens. In routine practice one method or the other should be adopted so your eye gets accustomed to any variation from the normal. Personally I prefer to contrifuge all specimens, even then I find many specimens which show only a few casts or pus cells that would not be found by the other method and which are pathological and demand attention. Albuminuria may occur without casts, but generally speaking, elimination of casts and albuminuria go together.

I have only touched the high spots and called your attention to the most important points of this test. I will not weary you longer, but want to make an earnest plea in behalf of your patients, that you give them the benefit of this important test, which can be carried out in your own offices with very little difficulty and with inexpensive equipment.

It is especially necessary to examine the urine often in children suffering from any of the acute infectious diseases. In patients suffering from any local infections, such as tonsils, sinuses or abscesses, and, of course, your obstetrical cases should have the urine examined at least once a week during the last few months preceding delivery.

EYE MANIFESTATIONS OF SYSTEMIC DISEASES*

H. J. BLACKMON, M.D., Tampa,

It is impossible to deal at length on such a broad subject in a paper of this kind, but I shall endeavor to cover the main points without too many details. It is my purpose to consider different diseases and relate how each may affect the eye. Having shown this, it will be seen how the eye serves as an aid in diagnosis. Many systemic disorders are manifested by ocular changes, thus making it necessary for the ophthalmologist and internist to work hand in hand. Very frequently the patient goes to the oculist for examination with an eye manifestation, the result of some unsuspected systemic disorder, thus putting him into a position to frequently be of valuable service both to the patient and internist.

The oculist may give very valuable information in cases of interstitial keratitis. The vast majority of these are due to syphilis. Bilateral interstitial keratitis is almost pathognomonic of congenital syphilis. Any paralysis of an ocular muscle in a patient under 45 is most probably due to lues. While it is well known that a typical Argyll-Robertson pupil usually means syphilis, more attention should be paid by the general men to slight changes which are of almost equal importance.

Cases of uveitis often occur as secondary manifestations of syphilis. Fundus examination will sometimes reveal evidences of previous choroiditis, the result of congenital syphilis.

There are many cases of iritis and choroiditis in which the vitreous is full of dust like opacities in which a Wassermann is more valuable than X-ray of the teeth or sinuses. While an oculist may make the first diagnosis of syphilis in early optic atrophy, these cases are rare. In every case of choked disk the possibility of cerebral syphilis should be investigated, which is the most frequent cause after tumor of the brain.

All forms of kidney disease which result in albuminuria may be complicated with retinitis, especially the atrophied kidney. Retinitis may be the only symptom for which the patient goes to the oculist for examination. At once it is recognized that the patient must be sent to the internist for examination. Occasionally it is an early symptom, but more frequently it is a late one. Transitory blindness may occur in nephritis with-

out a retinitis. The relationship between kidney disease and retinitis is poorly understood. The ocular disturbance is probably an extension of the degenerative changes in the vascular system to the small vessels in the tunics of the eye. Accurate information of these fundus lesions from the oculist provides a valuable guide to the internist for the diagnosis, prognosis, and care of the patients suffering with kidney and arterial disease. Concerning the prognosis as to vision, it is generally unfavorable. As to life, renal retinitis is an unfavorable symptom. Many patients die within two years and a considerable percentage die within the first year. There are, however, many exceptions to this rule.

The oculist may often be of service to the obstetrician. Cases of albuminuria in pregnancy may or may not show a retinitis. As a rule, if this does occur in the last two weeks of pregnancy recovery of vision follows. When retinitis begins about the eighth month, only half of the patients recover vision and a large percentage do not materially improve. When retinitis begins about the middle of the seventh month or earlier and pregnancy is not terminated, there is usually permanent blindness. With termination of pregnancy the retinal lesions may subside and good vision be restored provided the process has not been present too long. With this information I hope I have made it clear that pregnant cases with an albuminuria can get valuable information from the oculist.

Examination of the retinal arteries gives very valuable information as to the condition of the arteries in the general circulation, especially those of the brain. From retinal arteriosclerosis, due to the local vascular changes, angiosclerotic retinitis develops. This is of serious import. In addition to its relation to nephritis it may be the forerunner of vascular sclerosis of the brain or indicate changes in the cerebral arteries. Their subjects are liable to cerebral hemorrhage and all its consequences.

Foci of infection may result in a number of eye diseases which I shall only briefly mention. These consist of iritis, choroiditis, retinitis, optic neuritis, choked disk, vitreous opacities and vitreous hemorrhages. When the focus is eliminated early enough, prompt recovery is obtained.

Next, let us take up the complications of diabetes. Cataracts are one of the most common complications. Unfortunately they make their appearance during the later stages of the disease

^{*}Read before the DeSoto-Hardee-Highlands County Medical Society, Arcadia, Feb. 10, 1931.

and are, possibly, not so favorably influenced by insulin. They may develop at almost any age. The earlier cases are usually binocular and rapid in development. In the young the prognosis is not favorable. Local treatment is useless, the lens usually becoming completely opaque. By the use of insulin, lens complications are becoming less frequent and certainly operative procedures are safer.

Diabetic retinitis is practically always bilateral. In any case of diabetes of long duration, retinitis is seldom absent. Opacities and hemorrhages in the vitreous occur more often than in the retinitis of nephritis.

Diplopia and ptosis are the most frequent extraocular complications of diabetes. In all severe cases of iritis, complications are likely and the prognosis for even useful vision may be poor. Disease of the optic nerve in diabetes generally presents itself as a retrobulbar neuritis. Quite a number of cases of true amblyopia are seen, in which cases the recovery of vision is slow, but with treatment of the diabetes, visual acuity is likely to improve.

Eye changes following head in juries are important factors when studied in connection with the general symptoms. We can help in estimating the extent of the injury and in determining the treatment.

Increased and increasing intra-cranial pressure can be determined by fundus examinations. Destruction of or injury to the visual centers or tracts can be demonstrated by a visual field when the patient is able to cooperate. The pupillary reaction does not play a very important part in the diagnosis of brain injuries. Generally there is contraction early as the result of concussion, followed by dilatation. Muscle paresis and paralysis also play a part in the diagnosis. X-ray alone is not, by any means, sufficient in the study of these cases.

Examination of the eye grounds should always be a part of the routine examination of any case of head injury. The visual fields should be taken when possible. When choked disk is found, together with other symptoms of increased intracranial pressure, operative interference is imperative. The relief of pressure in practically every instance prevents consecutive atrophy of the optic nerve when done in time. Symptoms of choked disc without other symptoms of increased intracranial pressure is not sufficient for operation, unless the intra-ocular manifestations are pro-

gressive. On the other hand the absence of choked disc should in no wise preclude operation when other symptoms indicate its necessity.

Concerning tumors of the brain, I shall say very little. You are all aware that the eye findings are very essential. The question of increased intracranial pressure is important. Equally important is a field of vision which will give definite information in regard to any lesion causing pressure on any part of the optic nerve, chiasm, or tract. This is a highly specialized field and I shall not burden you by going into it.

In epidemic encephalitis the eye symptoms are often the earliest. History of transient double vision or an extra-ocular palsy is very important. This occurs in at least two-thirds of the cases. It may precede or follow the lethargy, but it occurs most frequently at the very onset of the disease. Another characteristic finding in this disease is loss of associative movements of the eye.

In meningitis, optic neuritis is present in about half the cases of the tuberculous type. Tubercles in the choroid may be seen but are comparatively rare. In epidemic cerebro-spinal meningitis extra-ocular palsy is common. The pupils are variable, nystagmus and ptosis may occur. Optic neuritis may occur, but is less common than in tuberculous meningitis. A striking feature in many cases is the marked variation in the eye symptoms from day to day.

Diagnosis of primary ocular tuberculosis is difficult. Secondary tuberculosis of the eye, of course, is associated with signs elsewhere. Tuberculosis should always be borne in mind when treatment of an acute or chronic process is not followed by improvement and when no other infection can be determined. These cases are often served well by referring them to an internist for an expert opinion.

Chronic forms of exudative choroiditis and cases with recurrent vitreous hemorrhages are very often caused by tuberculosis. Tuberculosis of the eye generally manifests itself in apparently healthy individuals in whom chest symptoms may never have been recognized, but careful examination by an internist often shows evidence of tuberculosis elsewhere.

The lesion in tuberculosis of the iris is always a secondary infection. Interstitial keratitis is tuberculous in only about ten per cent of the cases.

All are more or less familiar with the eye findings in exophthalmic goitre. The exophthalmos varies from a mere prominence of the eyeballs to a degree of protrusion so great that the eyelids are unable to close. On rolling the eyeball downward the upper lid follows slowly or does not move at all. This is an early symptom and is easy to demonstrate by the general men. There may be imperfect power or diminished frequency in winking, also widening of the palpebral fissure producing a peculiar stare.

Practitioners treating diphtheria should watch for eye complications. These usually develop during convalescence in the third or fourth week after the onset of the disease. The most common disturbance is failure of accommodation from paralysis of the ciliary muscles resulting in inability to focus the eyes upon near objects. Strabismus from paresis of the extra-ocular muscles, especially the external recti also occurs frequently. In this connection it is important to remember that any eye disturbance, even the apparently insignificant ones, should be thought of as post-diphtheritic paralysis.

Ocular complications in small-pox are less common since the introduction of vaccination. Severe conjunctivitis and ulceration of the cornea sometimes occur when the lids are involved in the pustulation. Pocks rarely form upon the eyeball.

In measles, conjunctivitis, ulceration of cornea and marginal blepharitis are sometimes observed.

With the exception of catarrhal conjunctivitis which occurs in many cases, eye complications in typhoid fever are comparatively rare.

In this paper, it has been my effort to avoid too many details and to refresh our minds with many special field with the hope of benefit to those who are interested.

THE RETRODISPLACED UTERUS JAY A. POWELL, M.D., West Palm Beach.

The frequency of this condition is so great that it is often taken as a matter of fact and comparatively little mention is made of it in current literature. This paper came to my mind after a review of a number of interesting cases and a study of those cases relative to their symptoms and pathological findings. In articles written by many investigators of note, there is probably no subject in the whole field of gynecology concerning which more divergence of opinion is expressed. So much is this difference of opinion in evidence, it is apparent that each case must be studied and treated on its own merits, and there is no rigid rule that

can govern the character and proper management of malpositions of the uterus.

There are many etiological factors as well as many different malpositions of the uterus. The causative factors may well be divided into two classes: the congenital or defective development and the acquired types. I will not attempt a review of all the malpositions but will deal principally with retroversion and prolapse due to relaxation of tissues as seen in the acquired type. This acquired type is that large group that demands intensive study and offers great promise both in the matter of prophylaxis and of permanent cure. This is true because this type comprises by far the largest number of cases of retrodisplacements and because it may be said that the acquired type is always associated with other pelvic conditions and therefore is generally symptom productive.

The supporting tissue of the uterus may become permanently weakened so that the fundus sags back from the bladder. This allows the intestines to enter the vesico-uterine space so that abdominal pressure is then exerted on the anterior portion of the uterus and serves gradually to force it backwards into the posterior culdesac. Thus the retroversion becomes permanent. The fundus of the uterus may be forcibly and permanently dragged back by the formation and shrinkage of adhesions that form between its posterior surface and the sacrum and the pelvic wall or by tumors attached to the posterior wall. Most cases of malposition of the uterus follow childbirth. All pelvic tissues, immediately following labor, are enormously hypertrophied and permanent laxness of these tissues results from an incomplete involution. The uterine vessels enter the uterus laterally and at a right angle; therefore, any backward rotation of the organ causes a torsion of the vessels so as to partially obstruct the veins. The enlargement of the uterus is at first due to engorgement, but the chronic state of congestion may result in a permanent hypertrophy of the uterine The ovarian vessels are also interferred with by the downward drag on the ovaries and broad ligament. The tubes are affected in a similar manner.

The incidence of retroposition of the uterus is about fifty per cent. Probably if obstetrical cases were observed over a more extended period, greater prevalence would be noted. It is not unusual to find a fundus in good position two months after delivery and find it in extreme retroversion

at six months post partum. In a majority of cases acquired displacement is preventable by proper treatment following the termination of pregnancy. Any measure directed toward the rapid resolution of traumatic injury, the result of labor, will lessen the likelihood of malposition. A lacerated cervix or peroneum is often the cause of subinvolution and consequent retroposition. Little can be done as to the prevention of the congenital type outside of general hygiene, diet, proper exercise and in an occasional case the use of glandular therapy.

Some women with a very marked degree of retroversion and prolapse exhibit no symptoms. The most common symptoms directly caused by retrodisplacement are backache and pelvic pressure; however, the pains in this connection are not characteristic. But we do know that the physical exhaustion resulting from retroversion and prolapse has a very important influence on the general health of the patient and especially the nervous system. It is a most common occurrence to see active, athletic, good tempered women, after several childbirths become nervous, irritable, unreasonable, easily exhausted and apparently completely changed both nervously and physically, as a result, I believe in many instances, of the constant pelvic discomfort and weakness from retroversion and prolapse.

Treatment.—If pessary treatment of acquired retrodisplacements is instituted early enough, cure can be reasonably expected. A pessary should be worn for a period of from one to six months, as well as the local treatment of cervical lacerations

and disease with antiseptic applications or even the use of the electro-cautery if indicated.

When more than one year has elapsed after the termination of the causative pregnancy, conservative treatment will not effect a cure. And even then, depending on the age of the patient and the character of her disability, it is often good judgment to defer operative treatment if transient relief can be obtained by palliative measures. When, however, the condition has progressed to the stage of definite anatomical impairment and structural atrophy, no palliative treatment will suffice and operation is imperative.

Any operative technique to be competent must include efficient care of all the associated pathology and contributing factors. A relaxed pelvic floor must be restored, a diseased cervix properly repaired and adnexal disease cared for.

For the retroposition there have been numbers of operations devised. Each and every one may in a properly selected case, effect an anatomical or a symptomatic cure, or both. No standardized technique can be applicable to all cases of retroversion. For retroversion with only a very slight prolapse the Baldy-Webster technique is probably the operation of my choice, but where the prolapse is marked, I follow a modification of the Olshausen technique. In either case there is little danger of intestinal strangulation, no contraindications to future pregnancy, nor is recurrence after labor likely if competent post partum observation and care are provided.

The Fifty-Ninth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

Will be held at

SARASOTA

May 3 and 4, 1932

EDITORIAL 337

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HOSPITALIZATION

Modern diagnostic methods and therapeutic procedures that require the use of costly scientific instruments on the one hand, and expensive drugs and apparatuses on the other, and that demand the services of high priced experts are, today, one of the most formidable problems facing hospital executives all over the civilized world. The constantly increasing number of new pharmaceuticals, serums and chemical compounds, which are produced at an exorbitant price and usually are restricted to intravenous and intraspinous medication, constitute some of the medicaments that are adding to the perplexities of hospital administra-

tors—not to mention the sick people in need of their curative powers.

The exceedingly delicate instruments now being devised to further the patient's welfare and cure, and the trained help incident to their accurate application, are playing their part towards intensifying the embarrassment of the hospital superintendent. One need to mention only the X-ray, the metabolism machine, the blood pressure instrument and the electrocardiograph, and, then, ask you to think back but a very few years in order to have you realize the stupendous ratio of increase that has arisen during the past few months in the daily employment of these expensive contrivances. It was just a few years ago when the electrocardiograph was viewed as a scientific curiosity; there were only a limited number of them scattered throughout the world and each one of those was looked upon more as an ingenious mechanical achievement than as an instrument of precision which was destined to play an essential part in the accurate diagnosis of heart disease. Today, an electrocardiogram is to be found in the file of practically every hospital patient suffering from cardiac pathology.

It is also not amiss to refer to a few of the elements and chemical compounds of high cost which require the services of a physician for their administration; for example, radium, the serums and the antitoxins, also all the remedies used intravenously and intraspinously; every one of these agents are not only in common daily use but their administration demands an aseptic technic. Is it any wonder that the continued addition of such high priced products is creating grave concern in the general economics of the treatment of disease, as well as exerting a marked effect upon the status of hospitalization.

And still the last word has not been said. Daily use is being made of the radio knife, the diathermy machine, the oxygen tent and the sun lamp, in the attempt to either increase the comfort of patients or prolong their lives. Science has actually developed a machine that will automatically continue a person's breathing in case the normal respiratory muscles cease to function. The initial cost of manufacturing such apparatuses, and the high charge for operating them are further exaggerating the tangled skein of responsibilities already accumulated by the hospital's chief executive officer.

Within the past week or ten days there appeared a news item in the daily paper which

stated that Prof. Wilder D. Bancroft, colloid chemist, and Dr. G. Holmes Richter, national research fellow, announce that they have made successful experiments with a chemical compound to combat the effect of drugs upon the nervous system. This is said to be a confirmation of the claims made 60 years ago by Claude Bernard, but which he was unable to prove with the inadequate scientific tools of his time. This proof is offered now by the application of colloid chemistry, one of the newest fields of science. Just two days prior to that announcement, another news item state I that the secret of life, for which science has been searching for years, may lie in the test tube in the biological laboratory of the Cleveland Clinic Foundation, over which the noted scientist, Dr. G. W. Crile, is the guiding genius.

Everyone admits that the value of these modern procedures and therapeutic agents to medical science cannot be overestimated, but one cannot help but wonder what is still in the offing. Nothing seems impossible anymore; it is not unreasonable to expect that in the very near future some one will discover a chemical compound, the productive cost of which will rival that of radium, but which scientifically prepared solutions will be injected into the brain stem itself as a means of revitalizing the brain tissues and stimulating the cerebral centers to a renewed activity. The procedure of giving this solution would necessitate the employment of a brain surgeon, and the technical preparation of it would call for the supervision of a highly scientific chemist. Again it would not be amiss to prophesy that, since a machine has been invented that will continue a person's breathing without any effort on the part of the respiratory muscles of that person, one will be invented which will continue the cardiac rhythm and automatically keep the blood flowing smoothly and continuously throughout the circulating system without any assistance from the heart muscle. Of course the employment of any of these superscientific methods implies hospitalization of the man or woman who is to receive such specialized treatment. Thus, it would seem that the cost of hospitalization bids fair to soar to heights never before dreamed about, and when it does there is sure to be created a deplorable dilemma for the already hopelessly puzzled hospital management.

This intricate problem of hospitalization, with its rapidly mounting financial tax, brings no item of worry to the pauper. The people of means are

in a position not only to meet their actual needs, but also to cater to their morbid desires, by having any one or all the new diagnostic procedures or modern methods of treatment which their money can purchase. As a result they can indulge themselves in relating to others how they reacted to the breathing machine, how the electrocardiac stimulator rested the muscle of their heart, and how it felt to have the new medicine injected into their brain, and finally how terribly expensive it was to take advantage of all these modern scientific achievements. But what about the bookkeepers, the clerks and the stenographers? How are they going to arrange to have themselves or their families, even in case of dire need, enjoy the benefits of even one of these modern methods of diagnosis and treatment and not pauperize themselves in the doing of it? It would seem that the wonderful advances now being made by science and scientific research are threatening to bring about a situation that may lead to the gravest results in the economic status of the hospitalization muddle. Going to a hospital as a patient is a necessity which comes to most of us at some period of our lives and it comes whensoever it will; this is the very best of reasons why all of its benefits should be kept forever within the financial reach of the masses and nothing be allowed to arise which might restrict them to the classes.

STATE NEWS ITEMS

Dr. J. P. Daniels, Pensacola, has returned from Shreveport, Louisiana, where he took a special course in rectal diseases conducted by Dr. Lawrence Goldbacher of Philadelphia.

* * *

Dr. and Mrs. Charles Lanier Park, Sanford, announce the birth of a son October 13th at Fernald Laughton Hospital.

* * *

The DeSoto-Hardee-Highlands County Medical Society met December 8th at the Santa Rosa Hotel, Sebring. New officers were elected, as follows:

President—I. W. Chandler, Avon Park. Vice-President—G. S. McKnight, Avon Park. Secretary-treasurer—L. W. Martin, Sebring.

The scientific program consisted of a four-reel movie on "Spinal Anesthesia" which was shown through the courtesy of H. A. Metz Laboratories, Inc., New York. This was enjoyed by all present

and Dr. H. V. Weems, Sebring, and Dr. J. A. Simmons, Arcadia, discussed the subject, giving their own personal experience and observation in the procedure.

* * *

The third radio broadcast of the State Association over WRUF, was given on December 30th by the Association's president, Dr. G. H. Edwards of Orlando. His subject was "The Medical Profession." The Music which interspersed the broadcast was furnished by the radio station.

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that at the meeting of the Board held in Jacksonville, November 23rd and 24th, twenty-three applicants took the examination, of which nineteen passed and were licensed, there being four failures. The successful applicants were as follows:

Anderson, Arnold S	St. Paul, Minn.
Bousfield, Roger E	
Burgner, Blanche A	
Cleverdon, L. A	
Dyrenforth, L. Y	
Ferrell, A. D	
Frobisher, Hamilton B	
Grimes, Ormand R	
Hart, Ruth S	
Hemphill, Stuart Price	
Lowenburg, Harry	
Owens, John Doster	
Owens, W. Duncan	
Smith, D. Lesesne, Jr	
Stapleton, J. L	
Thurston, Leon	
Turner, Roy J	
Wells, John Sam, Jr	
Woodruff, Ralph G	
,	

The Board refused to accept the applications of five applicants; two on the grounds of their being graduates from low-grade medical colleges and three who graduated from foreign medical colleges, on the grounds that they could not speak, or write, the English language.

The next meeting of the Board will be held in Tampa, June 13th and 14th, 1932.

* * *

At the December meeting of the Hillsboro County Medical Society, the following officers were elected for 1932:

President—L. F. Carlton, Tampa.

Vice-President—E. S. Gilmer, Tampa.

Secretary-Treasurer—J. T. Cowart, Tampa.

Board of Censors—W. J. Lancaster, W. M. Rowlett, and J. J. Saxton.

Delegates—R. P. Henderson, B. W. Lowry, W. P. Adamson, C. A. Andrews and J. R. Boling.

Dr. A. L. Rowe has resumed practice at Lake Worth after having completed a two-year post-graduate course in urology.

* * *

Dr. Sylvan McElroy, 48, Orlando City Health Officer for the past fifteen years, died suddenly on January 1st.

Dr. Wilbur O. Arnold of West Palm Beach recently returned from a four-month post-graduate course at the University of Vienna.

* * *

Dr. and Mrs. B. F. Woolsey of Jacksonville recently returned from a Christmas vacation trip to Oklahoma City where they visited Dr. Woolsey's parents and relatives. They report a pleasant trip.

Dr. and Mrs. Frank John Costa, Tampa, announce the birth of a son, Arthur Lewis, on November 30th at Centro Asturiano Hospital.

* * *

The Seminole County Medical Society held its December meeting at the Celery Club and was called to order by its president, Dr. H. D. Smith. Dr. G. H. Edwards of Orlando, president of the State Medical Association, gave an excellent talk on the activities of the State Association. The election of officers for the year 1932 resulted as follows:

President—J. William Martin, Oviedo.

Vice-President—J. Nolley Tolar, Sanford.

Secretary-Treasurer—J. T. Denton, Sanford.

Councilor (three years)—C. L. Park, Sanford.

Delegate to House of Delegates—R. E. Stevens,
Sanford.

Legislative Committee—A. W. Knox, J. N. Tolar, C. L. Park.

The annual meeting of the Pasco-Hernando-Citrus County Medical Society was held with Dr. L. T. Furlow, Brooksville, Florida, Thursday evening, December 10th. The following officers were elected for 1932:

President—A. B. Cannon, Lacoochee.

Vice-President—Leland H. Dame, Inverness.

First Vice-President—L. T. Furlow, Brooksville.

Secretary-Treasurer—G. R. Creekmore, Brooksville.

Other officers were: Dr. T. F. Jackson, Dade City, Delegate to the House of Delegates, and Dr. George A. Dame, Inverness, Alternate Delegate to the State Convention which will be held at Sarasota in May.

Dr. R. H. Williams has returned from postgraduate study in Vienna and re-located in Eustis.

Dr. J. N. McLane and Dr. R. G. Nobles, Pensacola, took part in the program of the Gulf States Medical Society meeting held at Atmore, Alabama, on December 10th.

* * *

The December meeting of the Broward County Medical Society was held at the home of Dr. Carlyle Yates, a retired physician. A buffet supper was served and a very interesting meeting ensued. The time of the regular monthly meeting was changed to the fourth Wednesday of each month beginning January, 1932. The newly elected officers are as follows:

President—R. H. Stovall, Ft. Lauderdale.

Vice-President—A. B. Connor, Hollywood.

Secretary-Treasurer—Anna A. Darrow, Ft. Lauderdale.

Dr. Robert E. Baldwin, Tampa, was recently appointed superintendent of the Tampa Municipal Hospital. Dr. Baldwin will remain head of the hospital's X-ray laboratory in addition to assuming the responsibilities of superintendent of the hospital.

* * *

Dr. and Mrs. Silas Eldridge Chambers. Miami, announce the birth of a son, William Eldridge, October 12th, at Riverside Hospital.

* * *

The Escambia County Medical Society met with City Manager George Roach and Dr. F. A. Brink, director of the Communicable Disease Bureau of the State Board of Health, on December 15th to discuss the establishing of a county health unit in Escambia County.

* * *

Dr. Walter D. Webb, who for some seasons past has been house physician at Hotels Ponce de Leon and Alcazar of St. Augustine, has moved to Boca Grande where he will be the physician for the Boca Grande Inn, Gasparilla Inn and Useppa Inn.

The Volusia County Medical Society met at DeLand the early part of December. A very interesting paper on "Hyperthyroidism" was read by Dr. Hugh West of DeLand. The second paper, of equal interest, was read by Dr. Charles A. Clemmer on "Arteriosclerosis." The election of officers for 1932 resulted as follows:

President—Joseph H. Taylor, DeLand.

l'ice-President - J. Ralston Wells, Daytona Beach.

Secretary-Treasurer—Joseph H. Rutter, Daytona

One Censor (three years)—J. E. Rawlings, Daytona Beach.

The doctors of the Jackson County Medical Society and their wives were entertained at a quail dinner by Dr. and Mrs. T. H. Hudgens of Sneads on December 8th.

Dr. and Mrs. Ralph Edwin Stevens, Sanford, announce the birth of a son, Ralph Edwin, Jr., on October 31st.

Dr. L. S. Laffitte, formerly of Gulf Hammock, is in Philadelphia where he is doing special work in urology.

At a joint meeting of the Lake and Sumter County Medical Societies held in Leesburg the early part of December, Dr. John E. Boyd of Jacksonville was guest speaker.

At the December meeting of the Marion County Medical Society, the following officers were elected for the year 1932:

President-T. H. Wallis, Ocala.

Vice-President—J. L. Strange, McIntosh.

Secretary—W. B. Jordan, Ocala.

Member of Board of Censors-E. G. Lindner, Ocala.

Dr. and Mrs. Milton M. Coplan, Miami, announce the birth of a daughter, Laura Van Kirk Coplan, on November 1st at Jackson Memorial Hospital.

Dr. C. J. Heinberg, Pensacola, was elected first vice-president of the Pensacola Kiwanis Club recently.

The Sarasota County Medical Society met in regular session, Tuesday, December 15th, electing the following officers for the ensuing year: President—Jack Halton.

Vice-President—O. H. Cribbins.

Secretary-Treasurer—Frank C. Metzger.

Delegate to House of Delegates—A. O. Morton.

Board of Censors—A. O. Morton, Chairman; J. C. Patterson, D. R. Kennedy.

The regular meeting of the Pinellas County Medical Society was held December 3rd at Clearwater. Dr. Louis Orr, Orlando, presented a paper on "The Urologist and the Practice of Medicine." Dr. G. H. Edwards, president of the State Association, addressed the society on "The Relationship of the Practitioner to the County Society and the State Association."

At a recent meeting of the Lake County Medical Society, the following officers were elected for the year 1932:

President-C. M. Tyre, Eustis.

Vice-President—A. L. Izlar, Clermont.

Secretary-Treasurer—W. L. Ashton, Umatilla.

Delegate to House of Delegates-H. G. Holland, Leesburg.

Alternate Delegate-R. H. Williams, Eustis.

* * *

At a recent meeting of the Palm Beach County Medical Society, the following officers were elected for the year 1932:

President—L. J. Netto, West Palm Beach.

Vice-President—J. L. Carlisle, West Palm Beach.

Secretary—V. M. Johnson, West Palm Beach.

Treasurer—F. K. Herpel, West Palm Beach.

Delegates to State Meeting-F. K. Herpel, A. L. Shackelford; alternates: L. J. Netto, L. A. Peek.

The fourth radio broadcast of the State Association over WRUF, was given on January 6th by Dr. Ralph N. Greene of Jacksonville. His subject was "The Medical Profession—Its Contributions to Charity in the State of Florida." The music which interspersed the broadcast was furnished by the radio station.

Dr. and Mrs. Joseph Halton of Sarasota recently made a trip to Hartford, Connecticut, to attend the funeral of Mrs. Halton's brother, Samuel Colt, who was killed in an automobile accident.

Dr. and Mrs. Gerard Raap, Miami, announce the birth of a daughter, Frances, on November 15th at Jackson Memorial Hospital.

* * *

Florida physicians who attended the twentyninth annual meeting of the Association of Seaboard Air Line Railway Surgeons in Miami, December 8-10, 1931, were as follows:

B. F. Barnes
J. G. Baskin
A. R. Beyer
B. M. BishopArcher
John Bowen
W. A. Brewster
W. D. Brinson
L. F. Carlton
C. D. Christ Orlando
G. R. Creekmore
J. B. CurtisOrange Heights
James A. Davis
J. Maxey Dell
J. C. DavisQuincy
Frank D. GrayOrlando
Ralph N. Greene
T. R. GriffinSt. Petersburg
E. J. HallMiami
Joseph Halton Sarasota
B. F. Hamrick
J. M. Hartley
E. G. LindnerOcala
T. M. McDuffee
W. E. MiddletonStarke
Ralph D. MurphySt. Petersburg
H. P. NewmanBartow
L. S. Oppenheimer
V. H. RagsdaleBradley Junction
H. H. Sapp Havana
C. W. Shackleford
R. D. Sistrunk
J. Robert Simpson
J. A. Smith
E. E. Strickland
H. V. Weems Sebring
F. S. Whitman
C. B. Wilson
R. C. Woodard
* * *

Dr. and Mrs. H. Mason Smith and their son, Mason, Jr., of Tampa spent New Year's with relatives in Douglasville, Ga.

* * *

At the regular annual meeting of the Dade County Medical Society held Friday, December 4th, the following officers were elected for the year 1932:

President—C. F. Roche, Miami Beach.

Vice-President—Elmo D. French, Miami.

Secretary—Robert T. Spicer, Miami.

Treasurer—Frank Davis, Miami.

* * *

Recently a letter was written to Dr. Meredith Mallory of Orlando by the American Medical Association relative to the National Society for the Prevention of Disease. A complete copy of the letter was mailed to all secretaries of component societies in Florida through our business office. A portion of the letter is reproduced below. Should more information be desired, kindly get in touch with your county secretary.

"It appears that E. J. Bryan, the organization Director, early in 1929 called upon some of the past presidents and the secretaries of the state and county societies and placed before them what appeared to be a commendable and laudable project.

"'Later developments seemed to show an extremely personal and commercial side for the organization and we (the physicians referred to above) demanded that he (E. J. Bryan) refrain from using our names. Since this we have heard nothing from him.'

"The information from this source states that the reaction toward the National Society for the Prevention of Disease is not at all favorable.

"From another source it is stated that the society was founded by Proctor Sigourney for the purpose of disseminating information about venereal disease. The consensus of opinion from this source is that the organization is commercial and the sale of pamphlets is only concerned. Another informant gives us the information that all registered mail sent to various addresses has been returned with one exception.

"Little is known of the men who signed the certificate of incorporation as directors. It seems that the organization director feels that the objects of the society are such that if adopted the practice of medicine will become revolutionized even without the complete cooperation of the medical profession.

"This organization is obviously another which has been started to get members. It is not apparent that there is great need for an organization of this type, since the American Medical Association and the several special societies for limited practitioners, the state and local health departments, the American Public Health Association, the Conference of State and Provincial Health Authorities, and other organizations in the field can accomplish all with their present organization and membership that could be accomplished by some new society which must needs spend a great deal of time and effort in building up its membership and prestige, after which it will be doing but a duplicating piece of work. In our opinion it is very difficult to understand the necessity for such an organization."

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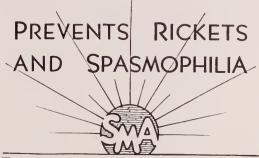
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MAY WE SEND YOU SAMPLES?



S. M. A. was developed at the Babies and Childrens Hospital at Cleveland, and is produced by its permission exclusively by



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DEAR DOCTOR:

One careful look at the advertising pages of your State Journal shows there are a dozen or more "first aids" for physicians to be had for the asking. A late issue contained, among others, these advertisements with the offer of free samples:

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WOMAN'S AUXILIARY

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In last month's issue, our page was so filled with the report of the meeting of the Auxiliary to the S. M. A., in New Orleans, that our State items were crowded out; therefore we hasten to enter these first this month.

DADE COUNTY

The following is taken from a Miami newspaper of November 9: "The Dade County Medical Auxiliary will sponsor the annual Tuberculosis Christmas Seal sale. This was announced at the meeting held vesterday at the home of Mrs. R. O. Lyell. Mrs. A. W. Wood was installed as president. Others to serve this year include: Mrs. J. M. Luke, first vice-president; Mrs. P. J. Manson, second vice-president; Mrs. S. Arnovitz, recording secretary; Mrs. George MacDonald, treasurer. Mrs. Wood has appointed the following standing committee chairmen: Mrs. H. A. Leavitt, entertainment; Mrs. E. J. Hall, music; Mrs. M. E. Threlkeld, membership; Mrs. C. Kirby-Smith, hospitality; Mrs. Edgar Peters, Hygeia Magazine; Mrs. M. J. Flipse, health education; Mrs. J. W. Snyder, finance; Mrs. Arthur L. Walters, publicity. The Auxiliary changed the date of the meeting to the third Monday in the month. Mrs. Flipse presented a health program recommended by the state auxiliary and it was

J. K. ATTWOOD, Pharmacist

Wade Bldg., 1022 Park Street. JACKSONVILLE, FLORIDA.

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PRESCRIPTIONS

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A bulletin furnishing detailed information may be obtained upon application to the

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See Description, Journal A. M. A. Volume XLVII, Page 1488

A scientific combination of Bismuth Subcarbonate and Hydrate suspended in water.
Each fluidrachm contains 2½ grains of the combined salts in an extremely fine state of subdivision.
Medicinal Properties: Gastric Sedative, Antiseptic, Mild Astringent and Antacid.
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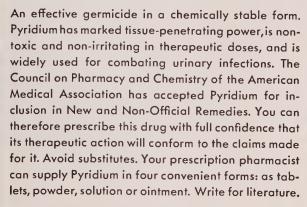
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Address communications to Brawner's Sanitarium, Smyrna, Ga., or to the city office, 478 Peachtree St., Atlanta, Ga.

DR. JAS. N. BRAWNER, Medical Director, DR. ALBERT F. BRAWNER, Resident Physician.



THE DOCTOR THE NURSE THE PATIENT

NO ONE is immune to perspiration and the discomforts and social implication that go with it, for perspiration often leaves in its wake an odor quite unpleasant.

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(AN ANTISEPTIC LIQUID)

checks the perspiration and prevents the odor, too. It needs to be applied only once or twice a week under the arms and to those parts of the body not exposed to adequate ventilation. Trial supply gladly sent to physicians.

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decided to devote the next meeting to this program."

VOLUSIA COUNTY

The Volusia County Auxiliary held its December meeting in DeLand. Dinner was served at the DeLand Hotel and following the dinner a business meeting was held.

On December 10, Mrs. J. Ralston Wells, publicity chairman for the Volusia County Auxiliary, spent the day in Jacksonville, where she was entertained for luncheon by our State President, Mrs. S. E. Driskell, at her lovely home on Windsor Place. Beside the hostess and her honor guest, there were present: Mrs. E. W. Veal, State Secretary-Treasurer, and Mrs. Edward Jelks, State Chairman of Publicity.

We promised to tell, in this month's Journal, about some of the good times we had in New Orleans at the meeting of the S. M. A. There was the usual president's reception and ball, and there were numerous teas, etc.; but (if one loves history and romance) the outstanding entertainment given us by our hostesses, the New Orleans and Louisiana Auxiliaries, was the personally conducted tour through the old French quarter. with luncheon in one of those fascinatingly beautiful old patios. It was all so picturesque and pregnant with romance and history that one actually went about in a dream. We were told that the (old section) "Vieux Carré" was laid out in 1718, and that all the streets are named for members of the French Royal family of that time. Here is the house where Dr. Antamarchi, Napoleon's physician, had his offices when he came to New Orleans to live, after Napoleon's death. It was Dr. Antamarchi, who is said to have made the clay mould, at St. Helena, from which the famous bronze death-mask of Napoleon was taken. This bronze mask, the city's greatest treasure, may be seen in the Cabildo. "The Cabildo"! a volume might be written about this onetime government building and prison, which is now used as a museum for New Orleans' historical treasures. Space will only permit this suggestion or finger-pointing toward the "Vieux Carré."

EXCERPTS FROM STATE PRESIDENT'S REPORT

The members of the Florida delegation, present at the business meeting of the S. M. A. Auxiliary, were proud to listen to the report given by our splendid President, Mrs. S. E. Driskell.

"Florida now has 12 County Auxiliaries, with a paid-up membership of 203. Each Auxiliary has



When decalcification occurs during pregnancy

It is important to warn expectant mothers of the danger of calcium deficiency during pregnancy. For unless there is sufficient calcium to take care of the developing foetus, there will be a withdrawal of calcium from the maternal structures—resulting, among other things, in rickets, soft bones, and carious teeth.

During this period Cocomalt is highly valuable for two reasons: It contains Vitamin D which mobilizes calcium, and it is mixed with milk which in itself is an essential source of calcium.

Recommend this delicious chocolate flavor food drink to expectant mothers. Not only does it contain Vitamin D—not only does it add 70% more nourishment to milk—not only is it tempting to finicky appetites—it supplies extra bodybuilding proteins, carbohydrates and minerals so essential to the mother and to the coming child.

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IN

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Cooperate with Nature combat intestinal putrefaction by using

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The food that promotes the growth of the normal protective germs

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SITUATIONS WANTED

Salaried Appointments for Class A physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoc's National Physicians' Exchange, 30 North Michigan, Chicago. Established 1896. Member The Chicago Association of Commerce.

DRUG ADDICTS

Drug and Alcoholic patients are humanely and successfully treated in Glenwood Park Sanitarium, Greensboro, N. C.; reprints of articles mailed upon request. Address W. C. Ashworth, M.D., Owner, Greensboro, N. C.

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Main Office and Plant--St. Augustine, Florida

The Medical Journal is printed by The Record Company, St. Augustine, Florida

been largely responsible for its own program. Some hold their meetings monthly, others quarterly. Some groups meet mostly for social purposes, while others have undertaken educational and philanthropic work, which has included health talks before various lay organizations, work with the Tuberculosis Association, Christmas seal sales, assistance to Hope Haven, the empty stocking fund and some social hygiene and other welfare work. Most of the Auxiliaries have been active in pushing the sale and use of the magazine Hygeia.

"This year we are urging all the auxiliaries to study a booklet prepared by Mrs. Henry Hanson, entitled, 'A Study Course on Florida's Medical and Health Laws' as well as to use the health studies sent out by the American Medical Auxiliary.

"Our Historian, Mrs. J. M. Irwin, has done a splendid work in arranging a very complete history and scrap book of our State Auxiliary. She has sent to Mrs. Oates, Florida's contribution to 'Our Medical Heroes' as follows: Stories of Dr. John Gorrie, the first man to manufacture ice, and Dr. J. Y. Porter, Florida's first State Health Officer, who held that position for twenty-eight years, and was largely instrumental in laving the foundations of our present state health laws. She also sent some sketches which she compiled on 'Old Florida Legends and Panacea.' These tell of some of the Spanish treatments and remedies connected with the early history of St. Augustine. She also sent a book entitled 'Dr. Andrew Turnbull and the New Smyrna Colony of Florida,' by Carita Doggett (Corse) of Jacksonville, Fla.

"The Editor and Business Manager of the Journal have been most courteous to us.

"The State Secretary-treasurer, Mrs. E. W. Veal, is attending to her duties in a most efficient manner.

"Our Advisory Committee of five members has been very cooperative.

"As President, I have tried to keep in touch with all officers, committee chairmen and county presidents by correspondence. I have written 115 individual letters about the work, since taking office in May, besides mailing out all the Southern and American literature that has been sent to me.

"There is much yet to be done in Florida, however many strong bonds of friendship have been established, and we are generally becoming more Auxiliary-minded."

* * * HERE

is one of the advertisements of The Sugar Institute

The advertisement reproduced here is one of the series appearing in publications throughout the country. In order to keep the statements in accord with modern medical practice, they have been submitted to and approved by some of the leading authorities in the field of human nutrition in the United States. The Sugar Institute, 129 Front Street, New York.



Those in charge of school luncheons are often confronted with the problem of getting children to eat what is good for them.

The lack of taste-appeal in the food served is often the reason that food is rejected or "picked at." Cooked tomatoes may be too tart, the stewed fruit insipid, the spinach and the carrots bland.

By flavoring or seasoning these essential foods with sugar they will be much improved in flavor. A dash of sugar to a pinch of salt is a good rule to follow in seasoning string beans, carrots, peas, tomatoes, soups and meat and vegetable stews. Fresh and cooked fruits should be sweetened to taste.

Doctors and diet authorities approve this use of sugar because it makes those foods which are carriers of vitamins, minerals and roughage, more enjoyable to the child. Flavor and season with sugar. The Sugar Institute, 129 Front Street, New York City.

"Flavor and season with Sugar"

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PACIOUS buildings, steam heated, with open fire-places in lobby and parlors. Library, sun parlor, broad veranda on entire front. A variety of indoor and outdoor recreations, including pool, tennis, miniature golf, and golf available. Fifty acres of beautiful grounds and walks. Dairy, vegetable garden, and poultry yards.

As the name implies the features of a hotel and of a sanitarium are here combined.

An ideal place for moderately indisposed, convalescent and rest cure cases as well as for the aged and infirm. A limited number of obstetrical cases cared for. Some remain the year round for the benefit of the equable southern climate, quiet atmosphere, mineral water and diet.

NO TUBERCULOUS OR MENTAL CASES RECEIVED.

Medical attention or supervision if desired, by a resident staff of four physicians and outside consultants. Diagnostic facilities and physiotherapy department.

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ADVERTISERS' NOTES

RESEARCHES IN CHEMISTRY

It can be said quite conservatively that chemistry affects every phase of our existence. Out of it have come wonders that stagger the imagination. The relationship between medicine and chemistry is a close one. The bacteriologist, the pharmacologist, the physician, and the pharmacist make daily use of their knowledge of chemistry. Without it, the work of Chen and Schmidt on the alkaloids of MaHuang could never have been accomplished.

For ages ephedrine-bearing ephedras have been native to China. The Pentsao, or Chinese dispensatory, has long recognized the drug. It remained for Lilly modern research facilities to make available a line of ephedrine products, each item of which is suited to particular requirements. No one comparing the uncertain strength of a messy infusion of the ancient drug to the convenient forms in which Eli Lilly and Company make available the various ephedrine products—pure, potent, refined, and concentrated—would be inclined to doubt the progress that has been made in research organizations such as Eli Lilly and Company, or the part that chemistry has played in that forward movement.

Mead's 10 D Cod Liver Oil is Made From Newfoundland Oil

Professors Drummond and Hilditch have recently confirmed that for high vitamins A and D potency, Newfoundland cod liver oil is markedly superior to Norwegian, Scottish and Icelandic oils.

They have also shown that vitamin A suffers considerable deterioration when stored in white glass bottles.

For years, Mead's Cod Liver Oil has been made from Newfoundland oil. For years, it has been stored in brown bottles and light-proof cartons.

Mead's 10 D Cod Liver Oil also enjoys these advantages, plus the additional value of fortification with Mead's Viosterol to a 10 D potency. This ideal agent gives your patients both vitamins A and D without dosage directions to interfere with your personal instructions. For samples write Mead Johnson & Company, Evansville, Ind., U. S. A. Pioneers in Vitamin Research.

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THE NEXT MEETING
OF THE
FLORIDA MEDICAL
ASSOCIATION
WILL BE HELD AT
SARASOTA
MAY 3-4, 1932

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY	CD-CD-UM + D-U		ME	ETINGS		Dues
SOCIETY	SECRETARY	Date	Time	Placo	Luncheon?	Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White Houso	Yes.	
Bay	D. M. Adams, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Laudcrdale.	4th Wednesday	8:00 P.M.	Chamber of Com- merce	No.	
Columbla	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustia	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden- Liberty- Wakulla- Jeffcrson	O. G. Kendrick, M.D., Tallahassee,	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.	1	t			
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	Yes.	
Pasco-Hernando- Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	F. C. Metzger, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital	<u> </u>	
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
Washington-						



FOR CONVENIENT RELIEF OF NASAL CONGESTION . .

While the Chinese drug Ma Huang has been used for centuries, the value of ephedrine—its active alkaloid—has only recently become known. Investigation has shown that it is effective in the treatment of nasal congestion.

Capsules Ephedrine Compound Squibb contain ephedrine oleate in combination with aromatic oils and preservatives in a petrolatum base.

CAPSULES EPHEDRINE COMPOUND SQUIBB

are supplied in convenient boxes of one dozen and can be used anywhere at any time. These flexible, long-necked gelatin capsules provide a simple, effective means of applying ephedrine without the use of an atomizer.

For further information concerning CAP-SULES EPHEDRINE COMPOUND and other Squibb Ephedrine products, write to the Professional Service Department, E. R. Squibb & Sons, 745 Fifth Avenue, New York City.

CAPSULES EPHEDRINE COMPOUND SQUIBB

THE JOURNAL

OF THE

Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

VOLUME XVIII NO. 8

Jacksonville, Florida, February, 1932

/ Yearly Subscription, \$3.00 This Copy, \$1.00

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

NEXT ANNUAL SESSION, SARASOTA, MAY 3-4, 1932

MEAD'S 10 D Cod Liver Oil with Viosterol

James M. Hoffman, A.B., M.D., Pensacola.

"If one wishes to fortify cod liver oil, it is far more reasonable and efficacious to increase its potency by adding a small amount of viosterol, which is a specific in the prevention and cure of rickets, as it brings about calcification not only of the bone but of the proliferating cartilage as well." (Hess, Alfred F., Am. J. Dis. Child. 41:1081; May, 1931.)

is the choice of many discriminating physicians because it represents the long pioneer experience of Mead Johnson & Company in the fields of both cod liver oil and viosterol. Mead's 10 D Cod Liver Oil is the only brand that combines all of the following features:

1. Council-accepted. 2. Made of Newfoundland oil (reported by Profs. Drummond and Hilditch to be higher in vitamins A and D than Norwegian, Scottish and Icelandic oils). 3. Supplied in brown bottles and light-proof cartons (these authorities have also demonstrated that vitamin A deteriorates rapidly when stored in white bottles).

In addition, Mead's 10 D Cod Liver Oil is ethically marketed without public advertising or dosage directions or clinical information. With Mead's — you control the case.

Mead's 10 D Cod Liver Oil is therefore worthy of your personal and unfailing specification. This product is supplied in 3-oz. and 16-oz. brown bottles and light-proof cartons. The patient appreciates the economy of the large size.

MEAD JOHNSON & COMPANY Evansville, Ind., U.S.A.

PIONEERS IN VITAMIN RESEARCH

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons.

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A statistical study of a series of over 9,000 cases showed a morbidity reduction of over 50 per cent when Mercurochrome was used for routine preparation.

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MIAMI FLORIDA CHARLES A. REED Owner, Manager



For the Scientific Treatment of Invalids, Mental and Nervous Diseases, Alcohol and Drug Patients.

> North Miami Avenue at 79th Street. Phone Edgewater 9144.

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21/4 cups hot water					
Grated rind Hemon 4 tablespoonfuls lemon	• • • •		• • • •	• • • •	
jnice	40.			4.	
2 tablespoonfuls sugar	16.	• • • •	• • • •	16.	
		9.		20.	116

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TONSILLECTOMIES WITH A REVIEW OF ONE HUNDRED AND THIRTY-FOUR CASES*

J. Newman McLane, M.D., Pensacola.

Before going into the subject of tonsillectomies, let us first consider the anatomy of the field with which we are dealing.

The palatal or faucial tonsil, commonly spoken of as the tonsil, is situated in a fossa between the anterior and posterior palatal pillars. Both in size and shape the tonsil varies extraordinarily. To understand variations, we must study the development of the organ. In the embryo at eight months, the form of the tonsil is fairly constant. After birth, the development of the tonsil is very irregular and its final shape and size depend upon the position and amount of adenoid tissue present. In the majority of cases the greatest amount of development takes place in the lower lobes. These by their growth project upward, and finally hide from view the superior lobe, which can be found only by looking deep into the supratonsillar fossa. If the adenoid tissue develops in the supratonsillar margin, a distinct tonsillar mass will be found in the palate and its growth downward leaves a fistilous tract running upward from the hilum of the tonsil. This unusual development probably accounts for our occasionally finding tonsil tissue in the supratonsillar fossa after a tonsillectomy.

The anterior pillar of the fauces is a fold caused by the prominence of the palatoglossal muscle, while the posterior pillar of the fauces is formed by the palatopharyngeal muscle. The space bounded by the two folds above and by the tongue below, is called the fossa triangularis; the tonsil lies within this triangle.

There are usually three distinct plica: plica triangularis, plica supratonsillaris and the plica retrotonsillaris. The plica triangularis is the most important plica because it is always present and quite frequently well developed.

Histologically the plicæ are reduplicated folds of muscosa with their fibrous layers in opposition. In these plicæ a varying amount of lymphoid tissue is found with shallow crypt formation. Leshin-

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

Pearlman' upon microscopic examination of the plicæ found definite lymphoid tissue deposits in 50 per cent of the plicæ, which is important because of the possibility as sources of secondary recurrence.

The blood supply of the tonsil comes chiefly through the tonsillar branch of the facial artery. The lower part of the tonsil is frequently supplied from a branch of the lingual, sometimes coming from the Dorsalis linguae and sometimes from the main lingual trunk. Occasionally the palatine branch of the ascending pharyngeal supplies the posterior or descending palatine.

The nerve supply of the tonsil is through a special branch of the glossopharyngeal, which, uniting with branches from the pharyngeal plexus, forms what might be called a small tonsillar plexus.

This paper is based upon 134 cases which I was able to follow up for at least six weeks following operation and one case which I saw in consultation four days after operation. The cases presented vary in age from three to 70 years and 84 of these cases were between 15 and 45 years of age.

The indications for tonsillectomy varied a great deal. Fifty-two complained of frequent attacks of tonsilitis and four of this number had had a peritonsillar abscess. The remaining 82 cases were referred for the removal of foci of infection. The two most important groups of cases were 43 whose predominant symptom was arthritis and 23 cases referred due to gastro-intestinal symptoms and only three of these patients gave a history of having tonsilitis.

In 96 of these cases a complete physical examination was done one week preceding operation.

The bleeding time varied a great deal with an average of two minutes and fifteen seconds, the shortest one minute and the longest six and a half minutes.

The anesthetic was general in 41 cases and 93 were under local anesthesia.

The general anesthesia of choice was an induction with nitrous oxide followed by ether, using an ether spray while operating to keep the patient perfectly relaxed, which latter condition I feel is most important in order to clearly see your field of operation. A great deal of faulty technique can be attributed to incomplete anesthesia.

Novocaine, 2 per cent, with 6 minims of 1/1000 adrenalin chloride to the ounce was the local anesthesia of choice. In patients who had a tendency to retch, a swab of 2 per cent cocaine was applied to the membrane of the nasopharynx. The average amount of novocaine-adrenalin solution used was 12 cc.

The operation of my choice was a dissection with scissors of the tonsil from the anterior tonsillar pillar similar to that used by Loeb² and completing the operation with a Sauer guillotine and snare. In using the guillotine method for the removal of tonsils, it must be remembered that the plica is usually not included when these instruments are employed. After the plica triangularis is removed, upon careful examination we sometimes find remnants of lymphoid tissue not previously seen at the base. I removed the plica triangularis and any lymphoid tissue seen with the snare. Some writers claim the removal of the plicæ will cause (1) changes in the voice, (2) prolonged convalescence, (3) more hemorrhage at the time of operation and increased postoperative hemorrhage. The free bleeding during operation I believe is true but can be easily controlled by suture if necessary, and this makes postoperative hemorrhage less likely. The removal of the plica and lymphoid tissue at the base will certainly prevent sources of further infection. I have not seen extensive scar contractions where only the plica and lymphoid tissue in the fossa were removed; and, without scar contractions, the voice will not be altered. The prolonged convalescence I attribute to faulty technique in injuring the underlying muscle. The advantage of the guillotine method is that I have never seen a posterior tonsillar pillar cut away with a dull guillotine, but the snare in the hands of the most skilled operators occasionally injures the posterior tonsillar pillar causing scar formation, leaving a dry throat which is irritated from the slightest postnasal drip. In extreme destruction of the posterior tonsillar pillar we often find some deafness in the patient at a later date, due to the contraction of the scar tissue.

In all patients given a general anesthesia, the nasopharynx was explored and any lymphoid tissue was removed with the LaForce adenotome and the finger, covered with a piece of gauze.

The hemorrhage immediately after removing the tonsils was sufficient in 17 cases that I put in a ligature of plain catgut size 00 using a full curved eye needle. Twelve of these were under general anesthesia, five under local. In 10 the ligature was

in the lower portion of the fossæ and in the other seven it was in the upper or middle portion.

There were three postoperative hemorrhages. One patient had a hemorrhage about two hours after operation and this was in the lower portion of the fossa and I ligated it. Pressure with soft cotton swab sufficed to control the hemorrhage in the other case, but the third case was from the nasopharynx and three drops of adrenalin 1/1000 in each nostril controlled the hemorrhage.

The only postoperative treatment given was a cleansing mouth wash of soda bicarbonate, drams one, and listerine, drams four, in a glass of water after eating. All patients were given three grains of powdered aspirin to hold in the mouth when the throat was painful and, if this caused any burning, they were advised to rinse the mouth with the soda-listerine mouth wash.

Eight patients complained of severe pain in the The examination of the tympanic membranes was negative. By frequently blowing aspirin into the tonsillar fossa and applying heat to the region of the temporal bone the pain was relieved. Two patients complained of severe burning of the throat after using aspirin. cocainized the mucous membrane in the region of the sphenopalatine ganglion in these two cases using the technique described by Guttman³. To cut my toxity to a minimum, I used a 4 per cent solution of cocaine instead of a 10 per cent. This partial cocainization completely relieved these two patients. Because of the communication of the nerves supplying the tonsillar area with those of the lining of the tympanum, mastoid cells and part of the external auditory canal we frequently have pain in the ears following tonsillectomy due to the irritation of the nerve endings of the tonsillar area. The upper two thirds of the tonsillar area is supplied by Meckel's ganglion, the lower one third by branches from the glossopharyngeal nerve. Meckel's ganglion receives a communication from the otic ganglion. The tympanic branch of the glossopharyngeal goes into the formation of the tympanic plexus and communicates with the otic ganglion. The auriculo temporal nerve from the otic ganglion supplies the external auditory canal and tympanic membrane.

SOME CONDITIONS MAKING TONSILLECTOMIES MORE COMPLICATED

In one case of a woman aged 28, who was six months pregnant, I removed the tonsils under local anesthesia with practically no bleeding. Tonsillectomy was advised after keeping the pa-

tient under observation for eight weeks. She first consulted me suffering with a peritonsillar abscess. This was opened, but her fever continued and her obstetrician found her urine loaded with pus. After two weeks treatment this subsided. One month later the patient again had an attack of acute tonsillitis associated with pyelitis and after this had subsided, I removed her tonsils, due to the severity of the attacks of pyelitis and, upon the advice of her obstetrician. The patient had a normal delivery and five months after the operation had had no further trouble with her throat or pyelitis.

A patient whom I operated upon developed a bilaterial iritis 10 days following operation. Under complete dilatation of the pupils for a week his condition cleared up and he had no further trouble six months later.

A boy aged 19 had nephritis for a year, to the knowledge of his physician. At the time I saw him his urine analysis was: albumen 4 plus with many hyaline and granular casts. After building the patient up with diet and general care his urine showed a trace of albumen. The patient refused a local anesthetic and was given a general anesthetic. The patient, in one hour after leaving the operating room, developed an edema of the hands and feet. This subsided in four days under medical treatment. With strict attention to diet the patient has been clear of albumen and casts for nearly one year.

Nine cases to my knowledge were in their secondary stage of syphilis and were receiving treatment. The average bleeding time for these luctic cases was three and one-tenth minutes. One of these cases had a bleeding time of five minutes and a coagulation time of ten minutes. One year previous she hemorrhaged freely while a laparotomy was being performed and the operation was not completed due to hemorrhage. This patient suffered with repeated attacks of tonsillitis and an operation was advised. She was put upon Ceanothyn, drams one, every four hours for one week, before operation and the day before operation, her bleeding time was three minutes and coagulation time six minutes. The operation was performed with little bleeding. The patient was kept on Ceanothyn, drams one t. i. d., for ten days following operation and made an uneventful recovery. The luetic patients suffered no ill effects from operation, except all these patients suffered with severe sore throats for about ten days following operation. Upon examination the throats looked like normal healing throats. The antiluetic treatment was discontinued in all cases two days before operation and again instituted in four days after operation, except in the case of the free bleeder in whose case no antiluctic treatment was carried out for two weeks after operation.

There were four cases with valvular heart disease, but all were compensating and made an uneventful recovery.

Two patients were in an active stage of tuberculosis but they suffered with so many attacks of sore throat that an operation was advised. One patient had a peritonsillar abscess two months before operation. A culture and smear was made from the contents for tubercle bacilli but none were found. This patient made an uneventful recovery from the operation, gained 17 pounds in six months, is able to oversee his farm, but is still under observation by his physician. The other tubercular patient made an uneventful recovery and was discharged from the state farm one year later as an arrested case with a gain of nine pounds.

A most unusual complication occurred in a case which I saw in consultation. On the fourth day after operation a dark V-shaped discoloration appeared in the tissue of the neck. The discoloration or hemorrhage extended from the level of the bifurcation of the common carotid arteries on each side above to the sternum below, bounded laterally by the sterno-mastoid muscles. The patient had a large clot in his right tonsil fossa. This condition I can not explain anatomically. The clot sloughed off in six days and in two weeks all discoloration had disappeared.

In six weeks following operation these 134 patients were examined and the following noted:

The children from 3 to 15 years of age gained an average of four and eight-tenths pounds in weight.

Forty patients, suffering from arthritis had noticed some improvement in their condition.

Two patients operated upon under local anesthesia had a tag of lymphoid tissue in the lower tonsillar fossæ.

CONCLUSIONS

In the nine cases in this series active syphilis prolonged the convalescense and the bleeding time.

The careful ligation of bleeding vessels at the time of operation prevents many hemorrhages following tonsillectomies.

The removal of the plica triangularis and any lymphoid tissue at the base is advised in order to prevent sources of infection.

In advising the removal of the tonsils as foci of infection the pathological condition of the tonsil should be considered, not the history as to whether the patient has or has not suffered with attacks of tonsillitis. BIBLIOGRAPHY

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DISCUSSION

Dr. H. Marshall Taylor, Jacksonville:

More than two thousand years ago Celsus described his finger enucleation of the tonsil. Since that time the throat surgeon has endeavored to add to his knowledge of the pathological tonsil and to improve his technique in the destruction of this source of infection. Volumes of literature have been published and innumerable instruments have been devised. Papers on the tonsil problem are always interesting to me, particularly if there are any new points developed.

Dr. McLane today has brought us another paper on tonsils. A review of the anatomy of the tonsil is ever interesting. What seems to me to be the cardinal point in his paper is his emphasis on the importance of preserving the pillars of the tonsil. This important step of the operation of tonsillectomy is apparently being utterly disregarded by many men who are doing tonsil work. This comes either through complete lack of knowledge of the subject, indifference, or inability to do good surgery. Any injury to the pillars of the tonsils followed by a cicatricial contraction interferes with the function of the palato-pharyngeus. The vocal chords are stretched by the contraction of the palato-pharvngeus muscle which tilts the thyroid upon the cricoid cartilage. This alters the character and pitch of both the speaking and singing voice, for which there is no remedy.

Another point in Dr. McLane's paper which interested me was that out of one hundred and thirty-four cases on which he performed tonsillectomies forty-three of them were suffering from some form of arthritis. This seems to me a very high percentage. With such a high percentage of arthritic cases it would have been of considerable clinical interest to have ascertained what was the prevailing type of bacteria in the tonsils removed. It has been my experience that the streptococcus hemolyticus is the prevailing organism in rheumatic cases.

Dr. McLane reports operating on two patients who were suffering from an active stage of tuberculosis. I cannot agree with Dr. McLane on this point. To my mind an active pulmonary tuberculosis is an absolute and positive contraindication for any tonsil surgery.

I have enjoyed Dr. McLane's paper and I feel that the association is indebted to him for his contribution

In closing, I would mention one other point in the post-operative care; that is, the insistence upon the intake of fluids. This can be made easier by the suspension of the head as advocated by Sanger.

USE AND ABUSE OF VIOSTEROL (IRRADIATED ERGOSTEROL) IN FLORIDA*

WARREN QUILLIAN, M.D., Coral Gables.

The widespread use of Viosterol during the past two years has aroused controversy concerning its advantages and dangers. There is a misconception that its inclusion in the dietary of the growing infant obviates the need for cod liver oil. Discussion in this paper will be limited to the clinical application of Viosterol-250 D in southern Florida; a summary of clinical results obtained in a series of fifty consecutive cases from the private practice of the author, observed over a period of six months from September, 1930, to March, 1931; and a description of certain toxic symptoms apparently due to Viosterol.

Research workers in the course of their study of various sterols discovered that ergosterol, (derived principally from ergot and yeast), in crystalline form or in solution possesses the power to absorb ultra-violet rays, thus increasing many times its vitamin D potency. Subsequent investigation, under the supervision of the Alumni Foundation of the University of Wisconsin, led to standardization by the Council on Pharmacy and Chemistry of the American Medical Association. The potency of Viosterol (irradiated ergosterol) in oil is measured by the methods used for determining the vitamin D potency of cod liver oil.1

The council, in accepting Viosterol for inclusion in New and Non-Official Remedies, states: "Viosterol is for use in prophylaxis and treatment of rickets and, experimentally, in other conditions arising from faulty calcium and phosphorus assimilation. It should be borne in mind that Viosterol does not contain vitamin A and that harm from hypercalcemia may result from the use of too large doses of the substance."1

^{*}Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

In Europe the discovery of activation was followed by hasty application to human cases. The products of different pharmaceutical firms differed greatly in potency. Despite this fact a uniform dosage was recommended. Great credit must be given to American workers and the cooperation of American pharmaceutical laboratories in their insistence upon a definite fixed standard of potency for all preparations of irradiated ergosterols prescribed for clinical use. In the following cases, irradiated ergosterol in the form of Viosterol (250 times the vitamin D content of cod liver oil) in oil was used, mixed with orange juice or tomato juice.

Fifty cases, ranging in age from two months to nine years, were studied in an effort to determine whether unfavorable clinical symptoms were being produced by the action of Viosterol. It was our impression that, unless at least ten drops of Viosterol per day were administered, a large percentage of the children were developing clinical symptoms and signs of rickets. Head sweating, beading of the ribs, enlargement of the distal epiphyses of the radius and ulna, cranio-tabes, bowing of the legs and pot-belly were considered to be the physical signs of significance in this study. With the use of small doses of Viosterol (under ten drops a day), it was observed that many of these objective findings developed, irrespective of the fact that all of these children received regular exposure to the direct rays of the sun. A check was not made with blood or roentgenographic studies. When Viosterol was administered in the recommended dosage (10 to 20 drops a day), many untoward symptoms developed. A further discussion of these will be made later. This preliminary report, based upon a comparatively small group of cases, is made to stimulate keen observation by the clinicians of Florida.

In normal individuals it is thought that the ultra-violet rays convert ergosterol in the skin into vitamin D. Wright² suggested that the value of Viosterol probably lies in its ability to increase the absorption of calcium and phosphorus from the bowel, thus raising a deficient blood calcium. Children of Florida are exposed to sunshine every month of the year. Does the high content of ultra-violet rays in Florida sunshine effect some change in absorption of ergosterol or supplement the action of the vitamin D? It seems that a logical explanation for the increased toxicity of Viosterol in Florida may be found in an increased

potency due to exposure of the patient to relatively larger amounts of ultra-violet irradiation than is available in other sections of the United States. Hess and co-workers3 at Chicago observed a slightly increased concentration of calcium, (11 to 12 milligrams to one hundred cubic centimeters of blood), when Viosterol was given during the summer months. They suggest that there is "little occasion for prescribing irradiated ergosterol at the season when effective heliotherapy is at our disposal." Our experience in Florida has been quite the contrary in that daily we see clinical cases of rickets and an occasional tetany among children who are frequently exposed to the sun here and who are able to be outdoors during every season of the year. Questioning of other physicians has revealed that this experience is general in Florida.4 Children are not rendered immune to rickets despite considerable exposure to sunshine. Therefore, it is reasonable to assume that some factors other than vitamin D deficiency must be considered in the etiology of rickets.

Klein⁵ demonstrated two years ago that massive doses of Viosterol fed to albino rats caused anorexia and loss of weight with a general impairment of the physical condition. Amounts used were far in excess of the usual therapeutic dose. We are not concerned in this paper with hypercalcemia or symptoms that may develop from tremendous overdoses of Viosterol. Ingestion of large amounts may lead to a withdrawal of calcium and of phosphorus from the body. Hess" has pointed out that the first manifestation of hypercalcemia is a failure of appetite. He states that he and his associates "failed to find irradiated ergosterol of value in the prevention or cure of respiratory infections or of anemia, in the healing of the ordinary fracture, or in the induction of growth."

In our series of fifty cases, the dose of Viosterol in no case exceeded thirty drops per day. The assumption was made that the Viosterol caused the unfavorable symptoms only when its discontinuance was followed by relief. The most frequent complaint of the mothers was the extreme fretfulness and restlessness of the child. It seemed that the general hypertonicity manifested itself next often in frequency of urination. By careful check-up we determined that this was in no sense a polyuria, but simply an increased frequency. We found no abnormal constituents in the urine. One child, (A. W.), a male, aged 18 months, who was receiving eight drops of Vios-

terol twice daily, had attacks of dysuria as well as increased frequency of urination. The muscle spasm preceding urination was often sufficiently intense to necessitate immersion of his entire pelvis in warm water before micturition could be completed. X-ray study and examination by a competent urologist failed to reveal any abnormality of the genito-urinary tract. Upon discontinuance of the Viosterol, the dysuria was relieved within ten days. This child had showed a persistent failure to gain in weight during the period that he was receiving more than ten drops of Viosterol daily. Possibly he was peculiarly sensitive to the action of Viosterol.

Among the fifty children observed during this study:

8 or 16% showed increased frequency of urination.

12 or 24% had marked restlessness or irritability.

8 or 16% persistently failed to show a weight gain over a period of several weeks.

5 or 10% had loss of appetite.

10 or 20% were constipated.

1 or 2% developed an urticarial eruption (generalized).

1 or 2% (described above) had dysuria.

12 or 24% failed to develop any abnormal symptoms.

In all of these instances, the symptoms were sufficiently marked to arouse the anxiety of the mother and to cause her to seek medical advice for relief. In some of the cases, two or more of the causes for complaint were present in the same individual. In the group there were no negroes, no premature infants and none suffering from intercurrent diseases. Three had definite rickets, which disappeared within a few weeks after Viosterol therapy was begun. No attempt has been made to compare results obtained in these cases with a similar series of controls, due to the variable conditions existing in the different homes and inability to check closely the cooperation of the parents.

A review of the literature on the subject reveals that investigators in other parts of the world have reported certain toxic effects from Viosterol, none of which we have observed. C. Weiner⁶ found pyelitis and nephritis in three cases on small daily doses. The potency of the product used is not stated. He urged caution in the employment of this drug. Putschar⁷ reports an instance of a non-rachitic male five and one-half months of age who

developed marked calcification of the tubules and interstitial tissue of the kidneys after receiving six drops of Viosterol daily for ninety-six days. The reports of injuries from the use of irradiated ergosterol in Europe can hardly be compared with those seen in this country on account of the variations in potency of the European preparations.

In September, 1930, an opportunity was afforded to study the clinical effect of an overdose of Viosterol-100 D. (This case was not included in the above series of fifty). A female infant, twelve weeks of age, had been perfectly normal in every way since birth. During the first ten weeks of life she had received breast milk with complemental feedings of modified cow's milk. Thereafter, the breast feedings were discontinued and she received a formula of cow's milk, water and Dextri-Maltose with vitamin B. At the age of two months Viosterol, one drop three times daily, was given. This was gradually increased within two weeks to three drops given three times daily.

The overdose was four times the amount prescribed (twelve drops). Within two hours symptoms appeared in the following order: profuse vomiting, followed by a watery green stool with foul odor. There was a great deal of gas expelled as flatus. After an attack of vomiting, the child was lethargic for a short time, followed by a long period of increased irritability. There was some prostration and stupor. It was seven days before the baby began to show progress toward recovery; and it was ten days before she became normal again. During this period no Viosterol was given.

CONCLUSIONS

- 1. Viosterol provides a valuable addition to our methods for the prevention and treatment of vitamin D deficiency.
- 2. Extreme care and keen judgment should be exercised in determination of the dosage of Viosterol among children in Florida on account of increased exposure to sunshine and an apparent sensitization to the action of Viosterol here.
- 3. An attempt has been made to stress interpretation of results according to clinical effect produced rather than effect upon blood calcium or roentgenographic studies. These laboratory aids are not available to the average physician without prohibitive expense to the patient.
- 4. Toxic effects are produced by Viosterol upon children in Florida by considerably less amounts than has been generally found by investigators in other parts of the United States.

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DISCUSSION

Dr. W. E. Ross, Jacksonville:

My experience with Viosterol has been more or less constant since its introduction to the medical profession.

I agree with Dr. Quillian in the fact that we cannot use as large doses in the South as probably are used in the North, and my personal observations are also to the effect that we do not get, with Viosterol, the results which we did get from the original combination of vitamin D and vitamin A as found in cod liver oil.

For the last six months, I have used cod liver oil in conjunction with Viosterol as a regular practice.

It has also been my experience that we avoid bad results by giving thyroid, and our results by giving pituitary and thyroid are very much better.

MALIGNANT MALARIA FEVER, A CAUS-ATIVE FACTOR IN HEMORRHAGE OF THE NEW BORN-WITH REPORT OF CASES*

J. G. GAINEY, M.D.,

Quincy.

Hemorrhage of the new born is a term applied to practically any condition whereby a loss of blood takes place independent of any visible traumatic lesions or evidence of invading bacteria or organisms. The presence of hemorrhage makes itself known by bloody, tarry stools, bloody vomitus, subcutaneous appearance of blood and frequent bleeding from eyes, ears and nose. large majority of cases occur within the first forty-eight hours while a few cases occur as late as the twelfth day after birth.

Hemorrhage of the new born may at times be confused with a hemorrhagic diathesis, but a differentiation can be made by remembering that hemorrhage of the new born occurs within the

first few days of life while a hemophiliac tendency most often makes its manifestation after the first year. The prognosis of the former condition is always grave while the latter with proper care and management may be prolonged with a certain degree of satisfaction.

Authoritative reference on the subject is at present rather scant and opinions vary considerably.

The etiological factors as given are (1) birth trauma (usually an unavoidable injury during instrumental delivery); (2) fetal malformations; (3) asphyxia; and (4) infectious conditions. (primarily syphilis). One authority states that a disturbed blood coagulation is present, associated with a lessened prothrombin content. He also believes there are a number of toxic agents which interfere with proper oxygenation of the tissues in a manner to excite the condition. Another writer states that such hemorrhages occur spontaneously and entirely irrespective of injury.

Since the influenza epidemic of 1918 many complicating disabilities arising later have been traced and proven a sequelae of the primary influenza infection. Also following the late World War, where the men came in contact with poisonous gases and were exposed to many other hardships, many very obscure disabilities especially of pulmonary and neurological tendencies have made themselves known and today constitute some of the most trying conditions to successfully manage that we come in contact with.

Likewise, in the tropical and subtropical sections, with the increasing seriousness in the past few years of the malarial situation many latent complications are easily traced back to the original infection. "The sequelae of malaria may be manifested in any or in all the tissues of the body. Only those affections, however, can rightly be classed as sequelae which are owing to the toxins generated during the active stage of the disease, to the hemolysis, or to the mechanical interference of circulation by the blocking of capillaries, and which manifest themselves after the subsidence of the exciting infection." (Solis-Cohen).

The course and management of malaria with an associated condition is exceedingly difficult and only by a reliable blood report and careful study can such cases be intelligently handled. Of special importance is malaria associated with pregnancy. With a febrile condition present plus the oxytoxic qualities of quinine as a specific treatment, we have two positive forces working against the one

^{*}Read before the Chattahoochee Valley Medical and Surgical Association, Albany, Ga., July, 1931.

desire of the mother to carry the child to term. However, the tendency of premature labor to follow a malaria infection may be one of nature's protective processes. Henson has observed abortion in one-fourth of the cases of estivoautumnal infections complicating pregnancy. This may be a conservative figure to cover the first half of gestation but recent experience has shown that during the last, and especially during the last few weeks of pregnancy, the percentage runs 90% and even higher. In such cases where the infection sets in during the last three to four weeks of gestation in a very severe form abortion is almost inevitable and the chances for a normal, healthy baby exceedingly rare. Present day authorities in tropical diseases agree that the theory of intrauterine transmission of malaria in any form is impractical. Syphilis not only affects the blood stream but may attack and produce pathology in any part of the body tissue, and is transmitted direct through blood stream from mother to fetus in utero and consequently gives rise to varied pathology and anatomical abnormalities in the growing baby. While in malaria infection its sequelae, as mentioned, may be manifested in any tissue of the body, there is no localized tissue destruction as it is conveyed to all parts of the body by the blood stream the same as a syphilitic condition. The localized changes brought about by a malaria infection takes place in such organs as the spleen, liver and brain, where through a congestive process the normal function may be greatly impaired or even destroyed.

In comparing the two conditions with a similarity of distribution throughout the body, we are well aware of the inherent tendency of the luetic infection, while in malaria the condition is not so universally distributed. There is sufficient evidence already known to prove there is quite a bit more to be learned about just what constitutes the abnormal bodily functions of an offspring from an acutely infected malaria mother. If the infection is not transmitted directly there must be some powerful toxins liberated from the mother's bloodstream detrimental to the existence of the offspring that the modus operandi remains unexplained.

I wish to report four such cases which is by far too small a number to prove anything definite in which a hemorrhagic condition set in shortly after birth and proved fatal in 75% of the cases. This, however, is conclusive evidence that undoubtedly something from the primary infection

is transmitted to fetus in utero to manifest itself shortly after the infant becomes free of maternal sustenance.

Case No. 1.—Mrs. C., age 23; white; 8½ mo. pregnant; mother of two children living and well; previous health—good; no chronic diseases; had first chill November 8, 1929, followed by daily chill and high temperature which would go to normal for a short time during early morning. Blood slide from two laboratories confirmed the presence of estivoautumnal malaria. Wassermann negative. Quinine treatment started at once. On November 11, 1929, three days later, labor pains set in and after a normal course, the mother gave birth to an 8½ mo. male baby, apparently normal and in good health. Twenty-four hours later the baby passed a large bloody stool which was followed by bloody vomitus. The bloody stools continued and submucous hemorrhage was noted. Clotting serum in repeated doses was given and symptoms abated for approximately 12 hours. After this, hemorrhage in a milder form recurred. The serum was kept up but to no avail and the baby died November 14, 1929, three days after birth. The quinine dosage to the mother was increased and response was

Case No. 2.—Mrs. X, age 30; white; 8 mo. pregnant; first child. Previous health—good. No chronic diseases. Had first chill October 25, 1929, followed by high temperature, extreme nervousness and headache and almost constant nausea and vomiting. Blood slide reports showed estivoautumnal malaria. Wassermann negative. Ouinine by mouth was started. On November 1, 1929, six days later, labor set in and an 8 mo. normally developed baby was born. On the second day frequent copious bloody stools were noted, followed by bloody vomitus and subcutaneous hemorrhage over the entire area of body. Serum was given but with no results and the infant died on the morning of the third day. A study of slides obtained from this baby showed many indications of a malaria infection. After the birth of the baby, quinine to the mother was increased with favorable results.

Case No. 3.—Colored patient, age 28, mother of 2 children, one living, one stillborn at term. Labor set in June 29, 1929, at 7 mo. pregnant. Patient gave history of having chills and fever for the past two weeks but took no treatment except chill tonic and aspirin. Blood slide showed malignant malaria. Wassermann negative. Labor

terminated about five hours after first pains began. A normally developed live male baby, weight approximately 5 lbs., was born. About twelve hours later the baby died. Examination showed much subcutaneous hemorrhage and the mother stated it had passed two large bloody stools and vomited some blood before it died. The mother had an uneventful recovery on quinine administration.

Case No. 4.—Mrs. J. W., age 19, with first pregnancy at term. I first saw this patient October 15, 1928. Light pains had already begun. Her temperature was then 103 by mouth. She gave history of having dumb chills and fever for the past week. A midwife was called in and assured her that she was all right and that her chills were only nervous rigors common in all cases with first baby just a short time before term. Blood examination showed malignant malaria the same day. Quinine by mouth beginning with small doses was started that night. Labor pains continued and the same night a girl baby apparently in good condition was born. The following afternoon the mother had the usual chill. The quinine dose was increased and continued until recovery. On the second day after birth the baby passed one bloody stool and on the third day several similar stools but no bloody vomiting occurred. Three doses of clotting serum were given at six-hour intervals. On the fourth day only traces of blood were noted. This baby made a good recovery and today is well and healthy. After the hemorrhagic condition in this case ceased there were no febrile symptoms noted. It was also noted that the convalescing period of this mother was much shorter than the three previously mentioned indicating a much milder type of infection.

CONCLUSIONS

- (1) The purpose of this paper is an endeavor to substantiate the fact that estivoautumnal malaria at certain stages may be transmitted in utero.
- (2) Estivoautumnal malaria is the main etiological factor in hemorrhagic fever.
- (3) Estivoautumnal malaria is a much more severe type of infection and is much more resistant to treatment than the tertian type.
- (4) The tertian is the type of malaria with which we are most familiar; it is very easily controlled; it does not produce the malignant or hemorrhagic type; it has not been proven that this type is transmitted in utero.

- (5) The four cases presented here were all expectant mothers within eight weeks of term and suffering from malignant malaria in the acute stage.
- (6) A careful study of blood slides obtained from the four infants previously mentioned revealed in two of the cases many indications of a malarial infection which is conclusive evidence that it was transmitted in utero.
- (7) Estivoautumnal malaria should be classed as a prominent etiological factor in hemorrhage of the new born.

PROGRESS IN PEDIATRICS* (A Few of the Advances Emphasized Recently at Harvard) WM. W. McKibben, M.D., Miami.

Introduction

When a member of your program committee. Dr. Watters, of Boston and Miami, asked me before Christmas, to prepare a paper covering the work of forty of my instructors in half that number of hospitals in and around Boston last summer, the hugeness of the task, on investigation, made it appear to be impracticable. However, our new secretary, Dr. Robert Spicer, suggested that I touch the high points of a few outstanding subjects. This I shall endeavor to do, hoping to stimulate others interested in pediatrics, who have promised to follow me this evening, to bring out further facts on children.

When I began the study of pediatrics in 1898, the fingers of one hand would cover the number of physicians practicing pediatrics, exclusively.

I recall only two medical schools having a distinct department of pediatrics: Harvard, under Dr. Thos. Morgan Rotch, who gave birth to the percentage feeding of babies, and Columbia, under Dr. L. Emmet Holt, who, with Dr. Rotch, helped to start the Walker-Gordon Milk Farms and Laboratories. Each wrote an excellent book on pediatrics.

It is true that there were some Infants' and Children's Hospitals, but no clean milk or infant welfare stations, no department of child hygiene, no public health nurses, X-ray, mental tests, psychoanalyses, radium, basal metabolism, Dick, Schick, or tuberculosis skin tests; we had no lumbar puncture with antimeningococcus serum,

^{*}Read before the Dade County Medical Society, Jan. 4, 1932.

no antitetanic serum, toxin-antitoxin, toxoid, convalescent serum for "polio", measles or scarlet fever; no intravenous arsenicals for lues, nor intraperitoneal injections for dehydration. Nor were we giving blood transfusions.

Vitamins for rickets, scurvy, beri beri, xerophthalmia, pellagra and other deficiency diseases were unknown, as were activated ergosterol and the hormones, like insulin. Striking advances have been made in preventing goitre and cretinism since then.

Curative, rather than preventive treatment was employed at the end of the 19th century, drug therapy instead of better health education, quarantine, nursing, correction of postural, dental, visual, aural, rhinological, and laryngological defects. Serology, immunology and biological chemistry have made profound strides. Yet, we are still far from the goal, as shown by the committee on Medical Care of the recent White House Conference, presided over by Dr. Ray Lymon Wilbur, U. S. Secretary of Interior:

Of 140,000 city, and 37,000 rural children surveyed, only fifty-one per cent of the former and thirty-seven per cent of the latter had ever received a health examination, most of which were made in the first year of life. Only thirteen per cent had received dental examinations, yet dental caries affects ninety-five per cent of the children well alkalinized with green vegetables, fresh fruit, and milk, avoiding an excess of acid-forming foods, such as sugar, starches and meats.

The figures on vaccination against smallpox and diphtheria immunization are still more startling. Only 22 per cent of the city children, and 7 per cent of the rural children, had been vaccinated, and only 22 per cent of the city and 18 per cent of the rural children had been immunized against diphtheria. Yet there are 55,000 unnecessary cases of smallpox in the United States each year, and in 1928 there were 5,000 seemingly unnecessary deaths from diphtheria, under five years of age; certainly a challenge to every city and hamlet, which can be met with astonishing results.

The chairman of the whole Medical Section of the White House Conference, Dr. Samuel McClintock Hamill, said at its conclusion: "This is a cooperative age. It is being stressed in every field of endeavor, but curiously enough, this committee has found few communities where health agencies are cooperating. The various organizations seem jealous of each other's prerogatives, competition replacing unified efforts."

"Knowledge is useless if not applied. The mere collection of facts is not alone unimportant, but it is the follow up and putting into practical application that counts." In a review of the findings of the Committee on Medical Care presented before the Massachusetts Committee for the White House Conference on Child Health and Protection, at its meeting in Springfield, Mass., Oct. 9, 1931, three ways to better child health were outlined:

1st. The medical needs of the child from birth to maturity.

2nd. The success or failure with which these needs are being met.

3rd. What ought to be done to fill in the many wide gaps existing in an ideally protective chain.

The medical needs are best met by adequate teaching of public, municipal, state and federal professional agents, and of physicians, nurses, dieticians and social service workers, many of whom are poorly prepared.

Hours of teaching pediatrics in schools are too few, as are the number of hospital beds for children, especially for sick colored children, and particularly for infectious diseases. Little provision has been made for convalescent care. Student nurses are being exploited for cheap labor in hospitals—proprietary schools, so-called.

At this New England conference this fall, Dr. Bronson Crothers, head of the neurological department at Harvard and of the Boston Children's Hospital, made a plea for more team work between the general practitioner and the psychiatric specialist; for an acquirement, too, of a more general intelligent attitude and working technique in psychiatry and psychology.

Psychiatric work in general and in children's hospitals is favored because of the close association under the same roof of general medical men, pediatricians and psychiatrists. The two latter used to become psychistrically intelligent and educationally sensitive.

Orthopedies and Body Mechanies:

This important branch is being sufficiently emphasized, but in many parts of the United States the cripple is still denied his place in the sun of efficient child health, through heliotherapy and corrective treatment.

Pediatrics should acknowledge the legitimacy of one of its own children, to whom orthopedic surgery for the last two hundred years has acted as foster-father. Hard to bring up, this child's name is Body Mechanics, nicknamed, Posture. Andry, the aged dean of the Faculty of Physic in Paris, in 1740, was the father, and Preventive Medicine, or Pediatrics, was its mother.

The body, a delicately balanced machine, has innecessary wear and tear, if out of alignment. Seventy-five per cent of United States children and the same of adults, exhibit faulty body mechanics and posture. This exerts an unfavorable influence upon growth and development with resulting poor functional health. It is not necessarily inevitable, and this handicap can be removed permanently.

Departments of general medicine, pediatries, orthopedies, nursing, physical education, public and private schools, hospitals and health centers should have adequate instructors in body mechanism under physicians and trained directors.

General practicians and pediatricians should note body mechanics in their regular physical examinations, and know the normal and practical measures for correction. This serious obstruction to physical fitness can be removed. Mind and body are linked together.

Besides more convalescent hospitals there should be clinics for health, body mechanics, posture, teeth and deafness. In the field of child hygiene the periodic health examination is accepted as a wise means of prevention, especially for the poorer classes.

As the subject of nutrition is so big, I have purposely reserved it for a separate paper I am preparing for publication. Suffice it to say that the sub-committee on nutrition calls attention to the great importance of their subject and to the fact that the so-called nutritionist should have a thorough basic training and that there should be more of them.

Infectious Diseases:

Of the many instructive cases seen, there was an interesting one of acute infectious mononucleosis with meningeal irritation and a pure lymphatic formula in the spinal fluid, illustrating the two types of the diseases.²

Ordinarily there are no cerebrospinal manifestations or change in the spinal fluid but an absolute or relative micreose in the lymphocytes of the blood to 40-75 per cent in a leucocytosis of about 14,000 per cu. mm., many being miniature pathologic forms.

The disease is similar to, if not identical with, glandular fever occurring in children; an acute

throat infection, enlargement of the lymph glands and spleen.

The meningeal type has an acute onset, vomiting, headache, fever, with the spinal fluid showing a marked lymphocytic pleocytosis without polymorphomiclear cells; it is self-limited and lasts 3-4 weeks.

The 1931 epidemic of poliomyelitis in New England and New York was the most extensive and destructive since 1916, but did not approach that year in numbers or severity. There were 21 cases for each 100,000 people in 1931 as against 53 in 1916; and 10 deaths per hundred cases in 1931 against 26 in 1916.²

Connecticut led the states and Brooklyn, the cities. The following states exceeded the average this last year:

Connecticut, New York, Massachusetts, New Jersey, Rhode Island, Vermont, Michigan, Minnesota, and Wisconsin.

The Harvard Infantile Paralysis Commission sent out physicians last summer by emergency airplane at the telephone call of the attending physician, whether the case be in the Connecticut Valley or away up in Vermont. If requested, they gave, say 20 c.c. of convalescent serum intraspinously and 60 intravenously; maybe repeated next day.

These parents now coming to Miami from afflicted cities feel particularly secure here in our potent ultraviolet rays and sunshine, where it seems difficult for the organisms of infectious diseases to grow.

The Commissioners and the Massachusetts State Board sent out requests for healthy people who had had an attack in the last 15 years. From these, blood was drawn for the serum and kept ready for demand.

Emphasis was placed on the necessity of parents and doctors alike, being alert during an epidemic for early symptoms of the pre-paralytic stage. It is then that the serum is of value.

There may be mild gastrointestinal symptoms such as nausea, vomiting, and pain in the pit of the stomach, with an obstinate frontal headache and a moderate temperature of 100 to 103.

The child may early show pain and rigidity in the back of his neck and later a "poker spine." He cannot flex his spine or lower his head to anywhere near reach his knees. He may have undue prostration, apathy, flushed face, or be alert and anxious if aroused; reflexes normal or overactive; Babinsky and Kernig often absent, a coarse

tremor, "tache cerebrale," tachycardia and congested throat.

There is an increase in the globulin, the spinal fluid pressure, and the cells (50 to 2,000, mostly 100 to 400). Polymorphonuclears may exceed at first but lymphocytes occur later. Fluid clear, but ground glass appearance against a dark background.

Most dramatic was the treatment of the bulbar type for respiratory failure, by the Drinker Respirator, invented by Dr. Philip Drinker and Louis Shaw of the Harvard School of Public Health.

The head protrudes from a large metal box; a rubber diaphragm fits snugly around the neck; an electric pump and a rubber diaphragm creates a vacuum sufficient to raise the chest, pull air into the lungs, the air being exhaled when the vacuum is released.

In some cases, after the edema has cleared up in the gray matter of the bulb, the child, although able to breathe again, became terrified at being "on his own" again, and had to be temporarily replaced into the respirator; the motor was started but not connected. When the child was convinced of the trick played on him, his morale was reestablished and he breathed perfectly well again.

The treatment of scarlet fever by antitoxin: Dr. Edwin H. Place, Clinical Professor of Pediatrics, Tufts College Medical School, Physician in Chief, Contagious Department, Boston City Hospital, in a paper read at the 150th anniversary of the Massachusetts Medical Society, June 9th, 1931, reviewed five years of antitoxin treatment of scarlet fever.³

At first its effect on toxic cases and on toxic symptoms of septic cases was striking, but soon was shown to lack effective action on the purely septic or endotoxic effects in most cases, which represent the most serious aspect of scarletina. Consequently, antitoxin has not been the therapeutic triumph that was hoped, and there is a tendency to give up, or at least to restrict its use.

Medical men find that the serum disease, occurring in 50 to 80 per cent, and severe in 10 per cent, is worse than scarlet fever. Dr. Place feels, however, that to avoid crippling and results, the patient has a better chance with antitoxin treatment, excluding possibly the mildest cases; especially is this so in surgical and obstetrical infections. Convalescent serum has the advantage of producing no by-effects and being suitable for intravenous injection. I noticed from the charts that only every other case was having the antitoxin treat-

ment. Dr. Place said that certain benefits may be secured, frequently great, by early specific therapy, yet there remains a great therapeutic problem in the septic complications which he describes in detail with the general management of rest in bed, suitable diet, good hygiene, and factors favoring an improved local and general tissue resistance. On septic sore throats, hot hypertonic glucose solution of 10 to 20 per cent is the most valuable treatment. Transfusion from convalescent donors is best treatment for septicemia. Septic arthritis is best treated with the Cotton treatment of washing out the joints and sewing up tight.

In uremia, limit food to glucose for a day or two; use hot packs or hot air baths once to six times daily; hypertonic intravenous glucose or magnesium sulphate; lumbar puncture if no result for convulsions; alkalies for acidosis.

Dr. Place believes in early drainage of infected ears, but Dr. Wesselhoeft questions the advisability of routine incisions of inflamed ear drums, with or without small blebs in them; he believes in early operation of mastoid infections and of bulging ear drums, and if there is severe pain with or without pus, then incise.

Tonsillectomies and adenotomies have become the most frequently performed of the major operations, in fact, in the nature of a racket. Is the casual inspection of the school doctor, or the school nurse sufficiently accurate to determine the need of the removal of tonsils and adenoids? If subjected to the influence of an artificial and deleterious environment, they become diseased, and if diseased, should be removed. Definite indications for removal are: scarred, cryptic or ragged tonsils with persistently enlarged cervical glands; large, definitely obstructive adenoids; a history of the rheumatic infections; a history of repeated sore throats; otitis media, or of frequent, severe, prolonged acute upper respiratory infections. In the absence of any of these indications, the burden of proof is on the person who would advise operation.4a

Observations at the Massachusetts General Hospital showed that in 51 cases blood sugar rose following operation in all, whether general or local anesthesia was used, brief or prolonged.

Other observers point out the similarity of socalled status lymphaticus, and cases of sugar shock from overdosage. They suggest that acute supra-renal insufficiency was responsible for the deaths classed as status lymphaticus. Blood sugar values in cases of enlarged thymus were normal or low. Others concluded that "there is no evidence that so-called 'status thymico-lymphaticus' has any existence as a pathological entity." ^{4b}

The ex-chief of staff at the Children's Hospital warned against contracting the thymus habit, or of developing "a thymus obsession", and of diagnosing congenital stridor, or a laryngismus stridulus, or even an attack of colic from sugar intolerance, as an enlarged thymus. Unnecessary treatment may possibly produce disastrous developmental results.

Returning to Harvard 31 years after graduating, and again contacting the old and new hospital wards, laboratories, dispensaries, lecture amphitheatres, and various institutions such as the Phelps Memorial at Newton Center, where there were about 200 cases of bone tuberculosis, one is, after all, most impressed by the tremendous reduction in the death-rate of the babies; from 14 per cent to about 7 per cent, just one-half. This has been due mostly to the decline in the gastro-enteric infections to only one-quarter of the original number.

Take, for example, the old Boston Floating Hospital. In 1900 it was not uncommon in walking across the gangplank, on arriving at Commercial Wharf at 9 a. m., to spot as many as nine dead babies waiting for admission. The dazed mothers left their homes all over Eastern Massachusetts with the hope that the salt air down Boston Harbor, plus good nursing and good feeding, would revive them. It was just such opportunities to study infant pathology that has been so potent in the advance in pediatric knowledge.

Sanitation, inspection, certification and pasteurization of milk; improved methods and simplification of the feeding of infants; education of mothers through lectures, demonstrations and literature—all these have made the great change.

The old Floating Hospital has been discontinued, and the On-Shore Hospital is now practically a milk and feeding research laboratory.

And this is a sign of the times. No longer is there a clinical expert, like Dr. John Morse, as chief of staff at the Boston Children's Hospital, and chief of the Department of Pediatrics, as formerly; but a research man, Dr. Kenneth Blackfan, with his corps of scientifically trained assistants from this country, and abroad.

I found also that the immunologist from the State Department of Health Laboratory had been lecturing to the members of the New England Pediatric Society on serum and vaccine therapy in children, trying to help them to separate the wheat from the chaff, the important from the unessential; another evidence of health education.

These clinicians will, in time, disseminate and apply the knowledge to the public.

Thus pediatrics has become a major department of medicine, a basic foundation for medical education.

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DISCUSSION

Dr. G. H. Withers, pediatrician of Miami Beach, discussed the importance of taking care of and immunizing the pre-school child, often neglected.

Dr. P. L. Dodge, neurologist of Miami, spoke of some of the advantages of the water or pool treatment for muscle training, in the New Bades Building, at the Boston Children's Hospital. He eulogized the great advantages of South Florida climate.

Dr. M. J. Flipse, internist of Miami, referred to the excellent heart clinic he attended a year ago last summer, at the Good Samaritan Hospital at Boston. He emphasized the point that the removal of focal infection alone does not necessarily cure rheumatic children in New England, but referred to the excellent results obtained last year at Miami Beach with six pitiful rheumatic heart cases from Boston, which showed gains in weight from eleven to twenty-five pounds each; from bed to beach in five months.

Dr. E. M. Jones, of Coral Gables, stated that the convalescent polio serum had been disappointing in New York.

Dr. W. Watters, of Coconut Grove, brought up three cases of which he knew in Boston recently that died suddenly; autopsy revealed definite findings of status lymphaticus.

Dr. Warren Quillian, of Coral Gables, emphasized the importance and advantage of the use of toxoid in immunizing babies against diphtheria; and of the preventive treatment of scarlet fever.

REPAIR OF SPINA BIFIDA (MENINGO-MYELOCELE) UNDER SPINAL

ANESTHESIA*

CASE REPORT

James M. Hoffman, A.B., M. D.,

Pensacola.

My purpose in presenting this case report is to call to your attention the practicability of the use of subarachnoid anesthesia in infants.

Baby W., born on August 26, 1931, female, poorly nourished. Family history negative. Normal delivery. Small swelling, about the size of a lime, noticed at birth in lumbo sacral region. This swelling became gradually larger. Was seen by me on September 19, 1931, at which time the swelling was about the size of a large orange, overlying the lumbo sacral region. Over the central portion the skin was parchment-like, thin and translucent. Transillumination was clear, which led us to make a diagnosis of simple meningocele. Because of the poor physical condition of the patient, the rapidly increasing size of the enlargement, and the fear of a spontaneous rupture of the sac, surgical intervention was decided upon. Operation was performed on September 25, 1931.

Because of the extremely poor physical condition of the infant, we were fearful of using a general anesthetic. The infant was strapped to the operating table by means of wide cloth bands over the chest and thighs. The sac was punctured with a fine gauge spinal needle and about 5 cc. of spinal fluid removed. In this fluid, 75 mg, of novocaine crystals were dissolved and reinjected without removing the needle. Pressure was then made at the puncture site to prevent the spilling of spinal fluid through the puncture opening. The head was then lowered. In about 10 minutes the lower extremities relaxed, and pinching of the skin below the waist evoked no response from the child.

An elliptical double incision was made at the highest point on either side of the sac, at which normal skin was encountered. The integument was dissected down to the vertebræ on either side, exposing the neck of the sac and the posterior spinal muscles. The sac was then opened and contents examined. It was found that several nerve trunks entered the sac, but were attached at their distal ends to the sac wall. These nerve trunks were dissected loose from the sac wall and replaced within the cleft in the vertebræ. The

neck of the sack was sutured and redundant portions of the sac with adherent skin removed. The stump of the sac was forced gently into the vertebral cleft. Closure was made in tiers, the innermost tier consisting of posterior spinal musculature and fascia. The second tier was made up of muscle and fascia pulled over from the middle portions of the contiguous musculature and fascia, which were relaxed by lateral incision in their bellies. The next tier consisted of subdermal integument united about one-half to threefourths of an inch from the free skin edges. The outermost tier consisted of loose approximation of the skin edges with silkworm gut. No attempt was made to do an osteoplasty, as the separation of the bony cleft was too wide. The final result showed a heavy pad of soft tissue over the original spinal defect. Fine, plain catgut was used to suture the neck of the sac. Heavy chromic catgut was used for the other layers, except for the outer skin, where silkworm gut was used. As the skin sutures were being placed, the infant cried for the first time since the first sac puncture was made. A protective dressing was placed over the incision, to prevent contamination from excretions of the child. Immediately upon returning from the operating room the infant was nursed by the mother and slept for about an hour.

No sedatives of any kind were used after operation. The infant was fretful for about 48 hours, but had no untoward symptoms. There was no apparent increase in intracranial tension since operation, more than was present before.

The convalescence was uneventful. The infant is improving steadily in general physical condition. There is a slight spasticity of the left lower limb, and a slight increased intracranial tension as evidenced by fontanel enlargement, which seems to be about the same as it was before operation.

CONCLUSONS

This case demonstrated to my mind:

- 1. The practicability of spinal anesthesia in infant surgery.
- 2. The absence of shock which usually attends an operation of this character.
- 3. The ability to continue diet management without interruption, which would not be the case if a general anesthetic were used.
- 4. The ease of making use of muscle and fascia pads when the tissues are thoroughly relaxed.

^{*}Read before the Escambia County Medical Society at its regular meeting on October 13, 1931, Pensacola.

EDITORIAL 377

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THE SOUTHEASTERN SURGICAL CONGRESS

A preliminary program of the third Annual Assembly of the Southeastern Surgical Congress, which is composed of surgeons from Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina and South Carolina, has recently been issued. This association will hold its next meeting in Birmingham on March 7-8, 1932.

The Southeastern Surgical Congress is an organization of especial importance to the medical profession of the South. It was organized in January, 1930, with the intent to supply to the seven southeastern states a surgical organization which was urgently needed. Prior to the forma-

tion of this society there were in the northern states twenty-two surgical organizations for 20,000 surgeons. The South had nearly 12,000 surgeons with but one surgical organization of limited membership.

The need for an organization to serve not only surgeons but also the entire medical profession in this district was apparent. Membership in this congress is limited not only to surgeons of recognized ability but also to surgeons who have definitely contributed to surgical progress by publishing original articles of value in medical journals. Membership is by invitation only and candidates are admitted only after they have complied with the rather strenuous regulations for admission. Up to the present time, Florida has some forty surgeons who have been admitted into the association.

Although its active membership is limited, the clinics and meetings of the organization are thrown open to the profession at large. At its last meeting in Atlanta a program of very high order was presented and an attendance of over 700 physicians indicated the appreciation of this program.

According to the announcement of the Birmingham meeting, the program there will be of the same high order as the previous meeting in Atlanta. The speakers who are already announced for this program are as follows:

Wm. Wayne Babcock, Philadelphia, Pa.; E. G. Ballenger, Atlanta, Ga.; Vilray P. Blair, St. Louis, Mo.; A. G. Brenizer, Charlotte, N. C.; Willis C. Campbell, Memphis, Tenn.; Geo. W. Crile, Cleveland, Ohio; T. M. Davis, Greenville, S. C.; John F. Erdmann, New York, N. Y.; Frank Hagaman, Jackson, Miss; Ralph N. Greene, Jacksonville, Fla.; Carl A. Hedblom, Chicago, Ill.; Chevalier Jackson, Philadelphia, Pa.; Frank H. Lahey, Boston, Mass.; Dean Lewis, Baltimore, Md.; C. Jeff Miller, New Orleans, La.; Fred W. Rankin, Rochester, Minn.; R. L. Sanders, Memphis, Tenn.; E. Laurence Scott, Birmingham, Ala.; Geo. T. Tyler, Jr., Greenville, S. C.

Later, invitations will be issued to all members of the medical profession in the southeastern states to attend this congress.

SECTIONAL MEETING, AMERICAN COLLEGE OF SURGEONS

The Sectional Meeting of the American College of Surgeons was brought to a close on the night of February 2nd, after a most successful and

interesting two days in Jacksonville. This Section of the College comprises the States of Alabama, Florida, Georgia, Louisiana and Mississippi; annual meetings being held in one of these States. These meetings are in addition to the regular annual meeting of the College of Surgeons which takes in the entire United States. The sessions got under way February 1, 1932, with a registration of about one hundred and fifty Fellows of the College in attendance. The mornings of Febrnary 1st and 2nd from 8:30 a. m. to 11:00 a. m. were taken up with interesting operative clinics at the various hospitals in Jacksonville, these clinics being held by the local Fellows in this city. The clinics were extremely well attended and proved of great interest to the visiting surgeons.

Clinical addresses by prominent surgeons from other States were largely attended and proved most interesting and instructive. George W. Crile, M.D., Director of Cleveland Clinic Foundation, talked on "A New Principle In The Prevention of Post-operative Pneumonia", and "Cardiac Decompensation and Suppression of Urine." He was followed by William D. Haggard, M.D., of Nashville, Tennessee, Professor of Clinical Surgery, Vanderbilt University School of Medicine, on "Syndromes of Goiter and Its Surgical Management." Further addresses were also given by John O. McReynolds, M.D., Dallas, Texas, Ophthalmic and Aural Surgeon, St. Paul's Hospital, on "Cataract and Glaucoma", and by Joseph C. Beck, M.D., Chicago, Illinois, Associate Professor of Otolaryngology, University of Illinois College of Medicine, on "Carcinoma of the Larvnx."

These clinical addresses were continued on the second day by Alfred W. Adson, M.D., Rochester, Minn., Associate Professor of Surgery, Mayo Foundation, on "Value of Sympathetic Ganglion-ectomy and Trunk Resection in the Treatment of Vascular Diseases—Raynaud's, Thrombo-Angiitis, Scleroderma and Atrophic Arthritis"; Joseph C. Beck, M.D., Associate Professor of Otolaryngology, University of Illinois College of Medicine, on "Recent Advances in the Treatment of Malignancies About the Head and Neck with Special Reference to Histopathology"; and John O. McReynolds, M.D., Dallas, Texas, Ophthalmic and Aural Surgeon, St. Paul's Hospital, on "General Considerations of External Disease of the Eye."

The afternoon of the second day was given over to a scientific meeting; papers being read by Doctors Daniel C. Elkin, Atlanta, Georgia; William D. Haggard, Nashville, Tennessee; Roy Holmes, EDITORIAL 379

Miani, Florida; Alfred W. Adson, Rochester, Minn., and George W. Crile, Cleveland, Ohio.

One of the objectives of these sectional meetings is the discussion of different aspects of hospital administration and other topics related to hospital management. These subjects were fully covered in different round table conferences.

The meeting was brought to a fitting conclusion on the evening of February 2nd, by a Community Health Meeting which was open to the entire public and which was largely attended by an eager throng seeking information concerning health problems and other medical conditions of interest to the laity. These community health meetings are an integral part of the sectional meetings, the idea being to present to the public those facts concerning public health, and various aspects of certain diseases, tuberculosis, cancer, acute appendicitis, etc., which are so urgently needed by the average layman. Interesting talks with suitable lantern slides and motion pictures were given by Doctors Alfred W. Adson of Mayo Clinic, George W. Crile, Cleveland, Ohio; John O. McReynolds, Dallas, Texas; Malcolm T. MacEachern of the American College of Surgeons, Central Office, Chicago, Illinois, and Mr. Robert Jolly, Houston, Texas.

The following members of the Plorida Medical Association registered during the meeting:

Alford, Neil	
Andrews, L. L	Orlando
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Blitch, Clifford G	. Jacksonville
Boone, James L	. Jacksonville
Boyd, John E	.Jacksonville
Brink, F. A.	. Jacksonville
Bryant, James M	. Jacksonville
Carlton, Leland F	Tampa
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Chilli, Jos. L.	. Jacksonville
Daves, F. E	hattahoochee
Davis, Julius C	Quincy
Day, Gaston	
Driskell, S. E	.Jacksonville
Duke, R. R	Tampa
Field, Thos. S	.Jacksonville
Fort, F. L	. Jackson ville
Gilmer, E. S	Tampa
Gray, F. D	Orlando
Greene, Ralph N	. Jackson ville
Hanson, Henry	. Jacksonville
Hargrove, J. L.	Bartow
Harkness, Robt. B.	Lake City
Heggie, Norman M	. Jacksonville
Helms, John S	Tampa
Helms, John S., Jr	Tampa
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Hurlburt, C. J.	Bartow
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Simpson, J. Knox
Snyder, John W
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Wylie, LeRoy A St. Petersburg

PRESENT-DAY PROBLEMS OF YELLOW FEVER

The United States Public Health Service has recently pointed out that except in reminiscence, the average physican rarely gives a thought to yellow fever. No doubt some believe that the disease has been almost eradicated and that it will soon disappear from the entire world; but it is by no means near extinction. There is a vast reservoir of yellow fever in west Africa; the disease still persists in certain parts of Brazil; and in 1929 it reappeared in Colombia. It is not only possible but extremely probable that, on account of increased and more rapid means of intercommunication, particularly increase in travel by airplane, yellow fever will reappear in many former endemic centers and even spread to countries never before infected, unless the strictest vigilance is maintained to prevent it.

The virus of yellow fever remains undiscovered. This unknown but living entity, when first it gains access to the blood of human beings, produces yellow fever in most adults, often resulting in death. However, in children, and also in many adults, the virus of yellow fever may be present

and complete its life cycle in the body without producing recognizable manifestations of its presence. This fact gives rise to large numbers of "missed" or unrecognized cases of the disease.

Until recently it was believed that a single mosquito (Aedes aegypti variety) was alone responsible for the transmission of yellow fever and that in the absence of this species, which does not breed in ground water, the disease could not be propagated. Then, too, it was frequently believed that this insect would not fly more than about 200 yards. We are now told that there are 13 species of mosquitoes that can convey yellow fever, and that Aedes aegypti will travel from 400 to 1,000 yards; that, under laboratory conditions, the virus of yellow fever may be passed from one mosquito to another; and that some of the newly discovered vectors breed in ground water.

Certain species of monkeys develop yellow fever when bitten by infected mosquitoes, and laboratory cases have occurred in human beings in which infection by mosquitoes could, apparently, be entirely excluded, suggesting infection by contact.

Efforts are still being made to immunize against yellow fever with, as yet, varying and unsatisfactory results.

It is hardly possible at this time to evaluate our newer knowledge of yellow fever or to express it in terms of prophylaxis and control. However, it is not believed that yellow fever is ordinarily contagious; and it is doubtful whether the transmission of the disease from mosquito to mosquito is an important factor in rapidly propagating the disease, though possibly it may be in maintaining its existence. It is still a question whether insects which breed in ground water are a serious epidemiological factor on this continent; but we can not ignore them. It seems most probable that the susceptible human (or animal) host is a necessary link in the continued existence of yellow fever in spite of the apparent demonstration of the infection of one mosquito by another.

To sum up the effect which this newer knowledge of yellow fever may have in combatting the disease, it may be said that, while these new discoveries enable us to combat yellow fever more effectively, they reveal to us the fact that our goal of complete extermination is, apparently, a far more formidable task than we were led to believe a few years ago.

The prevention of the spread of yellow fever and its eradication can no longer be regarded as the individual affair of the nation in whose territory the disease exists; it is a matter of interest to the entire world. The presence of yellow fever in one country is the immediate concern of all countries within striking distance of the disease and, for humanitarian reasons, the collective concern of all civilized nations. There must be no retrogression nor relaxation of effort in the struggle to control, and eventually to exterminate, this dangerous disease. On the contrary, there should be a forward, a continuous, a persistent attack on every lurking focus until yellow fever is annihilated, even though it should require decades of effort to accomplish this result.

So long, however, as vellow fever remains in the territory of any country, other nations with infectible territory must necessarily exercise the right to quarantine against those places where the disease exists. Quarantine measures which afford full protection today may be found to be wholly inadequate tomorrow, depending on the appearance of new foci and the development of new and more rapid facilities for intercommunication. The necessity for quarantine measures against yellow fever increases with proximity to the focus of infection, with the extent of the infection, and with rapidity of travel. Ports and places in many parts of the world that were formerly weeks apart by ordinary means of communication are now within a few days of each other by airplane.

PRESS RELEASES

Newspaper releases and announcements of radio broadcasts have been given to all the newspapers of the state. The press releases have been going out weekly the past nine weeks. In order that the Public Relations Committee may learn of the reception their press releases are receiving, all members of our Association are requested to clip the items appearing in their local papers and forward them to Box 81, Jacksonville. The clipping of these releases and forwarding them to the central office will be of considerable help to the Public Relations Committee as an indication of the value of the task they have undertaken. There is considerable cost in connection with these press releases and an enormous amount of work being done in the preparation of suitable articles and it is, therefore, quite important that reliable information be received regarding the number of papers in the state that have given space to the Committee's press releases.

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409 Ingraham Ridg Miami
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709 Huntington Bldg Miami Grimes, Dewey Herbert.
P. O. Box 377 South Miami Haggard, Wm. Andrew
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712 Huntington Bldg Miami Jenkins, Paul K., 604 Fifth St Miami Beach Jones, Walter Colquitt, Jr., 409 Calumet Bldg Miami
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STATE NEWS ITEMS

Dr. J. C. Patterson is the newly elected Secretary of the Sarasota County Medical Society.

* * *

Dr. G. H. Edwards, president of the Association and Dr. Wm. H. Spiers, member of the Executive Committee, both of Orlando, were recent visitors in Jacksonville. They met with Dr. Gerry R. Holden, chairman of the Executive Committee, and Dr. Shaler Richardson, secretary of the Association, in connection with Association affairs.

* * *

Dr. H. Mason Smith of Tampa was the honor guest of the Tri-State Medical Society of the Carolinas and Virginia and made an address on the evening of February 15th. The title of his paper was "Cerebral Mechanism of Sleep, and Its Disorders."

* * *

Dr. W. L. Shackelford of West Palm Beach on July 1st will become president of the Florida Hospital Association. Dr. Walter A. Weed of Lakeland was elected president-elect.

* * *

A clinic was held in Orlando for crippled children, January 30th, sponsored by the American Legion Memorial Post No. 19. Thirty-five crippled children were given attention at the clinic. Dr. Prescott LeBreton of St. Petersburg conducted the clinic and was assisted by Drs. C. D. Christ, Frank Gray, Wm. Sinclair and G. S. Osincup.

* * *

Dr. and Mrs. Homer L. Pearson of Miami announce the birth of a daughter, January 30th, at the Jackson Memorial Hospital.

* * *

Dr. Alvin Stebbins recently opened an office in Howey-In-The-Hills, Florida, having been previously located at Decatur, Georgia.

* * *

Dr. and Mrs. W. H. Y. Smith of Perry were in Jacksonville attending the Florida Public Health Association meeting in December.

JAMES E. GOETHE

Doctor Goethe began the practice of medicine in Georgia some forty years ago, shortly after his graduation. He located in Jacksonville about eighteen years ago and affiliated with the Duval County Medical Society and the Florida Medical Association soon after his entrance into the state.

Dr. Goethe was a man of quiet and unassuming demeanor; conducted himself as a gentleman; made friends with many; and was loved and respected by his clientele. He was gentle and kind in the sick room and assuring to the sick, relatives and friends.

He was married and reared a family of children, all of whom called him blessed.

He died on February 1, 1932, at the age of 77 years, as chronicled in the daily press. The Florida Medical Association has lost a worthy member and extends its sympathies to the bereaved family.

Dr. S. R. Norris, chief of the obstetrical service of the St. Lukes Hospital, Jacksonville, was recently one of the weekly speakers who appeared before the nurses' graduating class. Dr. Norris emphasized the part nurses can play in reducing maternal deaths and urged them to take active part in educational programs through their influence in the homes.

* * *

Dr. R. L. Miller of Graceville has announced his intention to run for the State Legislature from Jackson County.

* * *

Dr. Henry A. Monat was recently transferred from the U. S. Veterans' Hospital, Lake City, to the regional office, Cincinnati, Ohio, where he will serve as surgical consultant.

* * *

Dr. and Mrs. J. M. Hoffman of Pensacola announce the birth of a son, Robert Dean, at the Pensacola Hospital, January 11, 1932.

* * *

Dr. M. V. Miller died January 25th at Palatka. Dr. Miller for the past three years has been associated with his brother, Dr. W. S. Miller, of Palatka.

Dr. Clarence D. Rollins of Jacksonville announces he has discontinued Rollins Hospital for Women and will practice obstetrics and gynecology at the other hospitals of that city. Dr. Rollins' office is in the Medical Arts Building.

* * *

The marriage of Dr. Alvyn W. White of Pensacola and Miss Annelu Purifoy of Brewton, Alabama, took place on October 22, 1931. Dr. and Mrs. White are at home to their friends at 715 North 18th Avenue, Pensacola.

* * *

Dr. L. M. Anderson of Lake City, a past-president of the Florida Medical Association, recently spent three weeks at the Howard Kelly Hospital, Baltimore.

RESOLUTIONS

On the Death of Dr. Sylvan McElroy by

ORANGE COUNTY MEDICAL SOCIETY

On January 1st, 1932, our brother in the Practice of Medicine, Dr. Sylvan McElroy, was suddenly taken from among us and transferred to the Great Beyond, into which all of us must sooner or later enter. A Floridian, born in Orlando in 1883, he received his education at Stetson and at the Medical School of the University of Maryland.

Sylvan, a man of decided opinion; firm in his friendships; unhesitating in declaring his position in all matters, cannot but have left a lasting impression upon all of us who knew him well. His wholehearted devotion in his work as city health officer and his positiveness in matters which he deemed best for the interests of the city and the development of public health features, has given to Orlando the credit of being in the van among the cities of the State in matters pertaining to public health.

And now, we, his fellow practitioners, members of the Orange County Medical Society, in session assembled, realizing our loss only too keenly and recognizing the void which his departure has made in this Society and in his home, do pause for a moment in our deliberations out of respect to his memory.

And further, it is resolved that these words be spread upon our minutes as a perpetual reminder to us of his many virtues and that copies be sent to the members of his bereaved family.

Dr. Albert C. McKenzie, a former member, who has been connected with the medical department of the United States Veterans' Bureau, Washington, D. C., for the past year, has resigned from government service and returned to Jacksonville to his office in the St. James Building where he will resume active practice of his profession.

* * *

The following officers have been elected by the Escambia County Medical Society, to serve for the year 1932:

President-J. H. Fellows, Pensacola.

Vice-President—J. N. McLane, Pensacola.

Secretary-Treasurer—J. M. Hoffman, Pensacola.

A. M. Ames, C. C. Webb and H. L. Bryans of Pensacola were elected to the Board of Censors.

* * *

The annual banquet of the Orange County Medical Society was held at Dubsdread Country Club, Wednesday evening, January 20th. Dr. Chas. W. Stiles, late of the Public Health Service, gave a talk upon complete eradication of hookworm disease.

* * *

At its December meeting, the Columbia County Medical Society staged a quail supper and had as guests several visitors from Jacksonville. Drs. Louie Limbaugh, T. M. Palmer and W. M. Shaw of Jacksonville presented an interesting symposium on "The Value of Mantou Tuberculin Reaction in the Diagnosis of Childhood Type of Tuberculosis." An interesting series of case histories with roentgenograms were demonstrated.

* * *

Dr. A. D. Stollenwerck was elected president of the medical staff of the Duval County Hospital at an annual meeting held recently by the Duval County Welfare Board. Other officers named were: Dr. Shaler Richardson, vice-president, and Dr. W. M. Shaw, secretary. Dr. J. Knox Simpson, retiring president, introduced Dr. Stollenwerck, who addressed a brief message to the session. Francis S. Mason, chairman of the Welfare Board, was another speaker. He paid high compliments to the 65 physicians and surgeons of the hospital staff who give their services without compensation to the indigent of Duval County.

* * *

Dr. C. W. Hoffman of the staff of the Veterans' Bureau Hospital of Lake City is spending a twomonths vacation visiting relatives in Arizona and New Mexico. The next written examination of the American Board of Obstetrics and Gynecology will be held in nineteen different cities in the United States and Canada at 2 p. m. on Saturday, March 26, 1932. The general, oral and clinical, examination will be held in New Orleans on Tuesday, May 10, 1932, immediately preceding the meeting of the American Medical Association. Reduced railroad fares will be available. For detailed information and application blanks apply to the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pa.

* * *

At a recent meeting of the Bay County Medical Society, the following officers were elected to serve for 1932:

President—Donald S. Fraser, Panama City. Vice-President—L. H. Bartee, Lynn Haven. Secretary-Treasurer—W. J. Lee, Panama City.

Dr. W. J. Blackshear of Panama City was elected as delegate to the annual meeting of the state association, with Dr. J. M. Nixon, also of Panama City, as alternate delegate.

* * *

The next annual session of the Medical Association of Georgia will be held in Savannah, May 17-20, 1932. Please note that this is a change of dates.

* * *

Dr. J. N. McLane of Pensacola returned recently from quite an extended trip through south Florida. He visited friends in Orlando, Miami Beach and Tampa.

* * *

The following officers of the Columbia County Medical Society have been re-elected to serve for 1932:

President—L. M. Anderson, Lake City.

Vice-President—R. B. Harkness, Lake City.

Secretary-Treasurer—T. H. Bates, Lake City.

* * *

Dr. H. Mason Smith, Tampa, president of the State Board of Health and Dr. Henry E. Palmer, Tallahassee, a member of the Board, were in Jacksonville February 9th attending the annual meeting of the State Board of Health.

A well-placed mashic niblick shot gave Dr. R. C. Denison of Lake Worth, who has been shooting in the first flight ranks for the last few years, his membership in the hole-in-one club, when his ball rolled into the cup of the fifth hole on the Lake Worth municipal course. The hole is a 116-yard, par three layout.

* * *

The annual banquet of the Pasco-Hernando-Citrus County Medical Society was held Thursday evening, January 14th, at the Tangerine Hotel, Brooksville, with the physicians' wives as special guests. The banquet table was artistically decorated with red roses; a beautifully appointed six-course turkey dinner was served. After the dinner hour, the guests were entertained by a classical dance given by little Miss Helen Barditzsky, followed by a violin solo by Mr. Chris Gilbert, and Mrs. J. C. Emerson at the piano. Mr. Roy Hunter was very amusing in a skit while Mrs. Mallard of Savannah, Georgia, and Mrs. H. S. Simmons of Brooksville vied in comedy readings. After the banquet, the ladies played bridge while the doctors held an installation program for the new officers.

* * *

The American College of Physicians recently selected Dr. O. T. Avery of the Hospital of the Rockefeller Institute of New York City as the recipient of the John Phillips Memorial Prize for 1932.

This prize, an annual award by the College in the sum of \$1,500, is given to perpetuate in the College the memory of Dr. John Phillips of Cleveland, a man of outstanding accomplishments as investigator, teacher and physician, for many years a member of the Board of Regents of the American College of Physicians, who gave his life in saving others on the occasion of the Cleveland Clinic disaster on May 15, 1929.

The Sixteenth Annual Clinical Session of the College will be held in San Francisco during the week of April 4, 1932. Dr. Avery will deliver an address, "The Role of Specific Carbohydrates in Pneumococcus Infection and Immunity", at the Convocation on Wednesday evening, April 6. At the conclusion of Dr. Avery's address, the prize will be presented to him by Dr. S. Marx White of Minneapolis, President of the College.

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WOMAN'S AUXILIARY

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The news item of outstanding interest this month is that the Florida Auxiliary is to have present at its annual meeting at Sarasota, in May, one and possibly two officers of the National Auxiliary; these officers are to be none other than the President and President-elect of this organization, Mrs. Arthur B. McGlothlan and Mrs. Walter Jackson Freeman. The Florida Auxiliary is indeed fortunate, and every member should endeavor to be present.

* * *

EXCERPTS FROM MRS. McGlothlan's Message to the State Auxiliaries.

"Dear Auxiliary Members:

"As we cross the threshold of a new year shall we, like other businesses, pause and take stock of ourselves to see where we have arrived in relation to the goal which we set for ourselves at our annual meeting?

"One of our goals, for this year, is an advisory council or counselor for each of our county and state Auxiliaries. Where does your own Auxiliary stand with relation to this goal? It is hoped that each state president, reporting at New Orleans, will be able to say that not only her state Auxiliary, but each of its constituent county units has an advisory council or counselor.

"Have you, as a county or state group, set a

goal for membership? Has your Auxiliary some sort of membership file, by which you have kept a complete record of members from the beginning of organization? Are you retaining as members all those who have ever belonged? If not, could you not begin this first month of the new year to re-enlist them? Our national files contain many cards of members which we have had to class as 'delinquents' because we have failed to receive dues for them or reports on them. Could not each organized county, that has not already done so, make a card file of its membership and report to the state office the names of those who have moved to another locality, and to a chairman, which each state president is being asked to appoint for that purpose, the names of those who have passed into the Great Beyond.

"It seems to me that each county administration should feel that it had failed somehow in its duty, if it had not made a sincere, persistent and tactful effort to hold in membership at least all those committed to its care by the former administration, and unless its membership is one hundred per cent of the wives of doctors belonging to the county medical society, it should make a definite, even though slight, gain.

"Some of the newly-organized Auxiliaries are attempting nothing more than to bring about unity and solidarity within the profession, by means of social contacts between the families of doctors. My observations on my visits to Auxiliaries during this year, lead me to believe that this function of the Auxiliary should not be underestimated. The medical societies are apparently more and more recognizing the forces, both within and without the profession, that are working counter to the best interests of the profession and the public, and are feeling the need of a *unifying* force, such as an Auxiliary may be, when given sufficient encouragement, cooperation and guidance by its medical society.

"The state Auxiliaries have made much progress this year in securing chairmen corresponding to the national chairmen. Our organizations cannot function properly until county Auxiliaries also have such chairmen, who will receive program suggestions and material from the state chairmen and who will report to the state chairmen on the progress of the county work. The function of the National Auxiliary is to stimulate interest in types of approved work possible to be done, and to serve as a clearing house for information on the kinds of work being done successfully by the



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various Auxiliaries. It is obvious that little interest can be stimulated, if there are not county and state chairmen corresponding to the national. How near to this goal is your Auxiliary?

"Where do you stand with relation to your Hygeia goal? The House of Delegates of the American Medical Association, in the Convention at Philadelphia last spring, asked that we 'recognize as one of our chief activities the promotion and distribution of this publication through parent-teacher associations, boards of education, and similar bodies interested in education.' If any of you are doubtful as to the helpfulness of Hygeia for teachers, mothers, nurses, or doctors, write to Mrs. R. N. Herbert, 1509 Stratton Ave., Nashville, Tenn., for a folder of 'Hygeia Talks', which will probably convince you. No woman, who is promoting the distribution of Hygeia, through schools, homes, or other educational groups, should consider herself a magazine solicitor, but instead should feel that she is an important factor in a health education project. devised and promoted by the American Medical Association, for the good of both the profession and the public.

"We believe that the national board meetings and conventions are so important in the life of the Auxiliary that every board member should consider it an obligation, when reasonably feasible, to attend. Mrs. Joseph Hume, of New Orleans, is the chairman of the next convention which is to be held next May 9-13. Our own President-elect, Mrs. Walter Jackson Freeman, who so skillfully guided the convention in Philadelphia, is also a member of the New Orleans Convention committee.

"There we shall find both pleasure and inspiration. May I hope to meet you there, one and all! May we have the satisfaction of reporting that we have reached all the goals set for the current year! There are yet three more working months in which to accomplish them.

"And won't you all be considering the goals we should set for next year?

"Faithfully yours,

"(Mrs. Arthur B.) Anna F. McGlothlan."

DUVAL COUNTY.

The Auxiliary of the Duval County Medical Society held its January meeting on the afternoon of the seventh, at the "Party House," with the new President, Mrs. E. W. Veal, in the chair. In the absence of Mrs. Jennings, Mrs. Wm. Kirk

William D. Jones

Pharmacist

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See Description, Journal A. M. A. Volume XLVII, Page 1488

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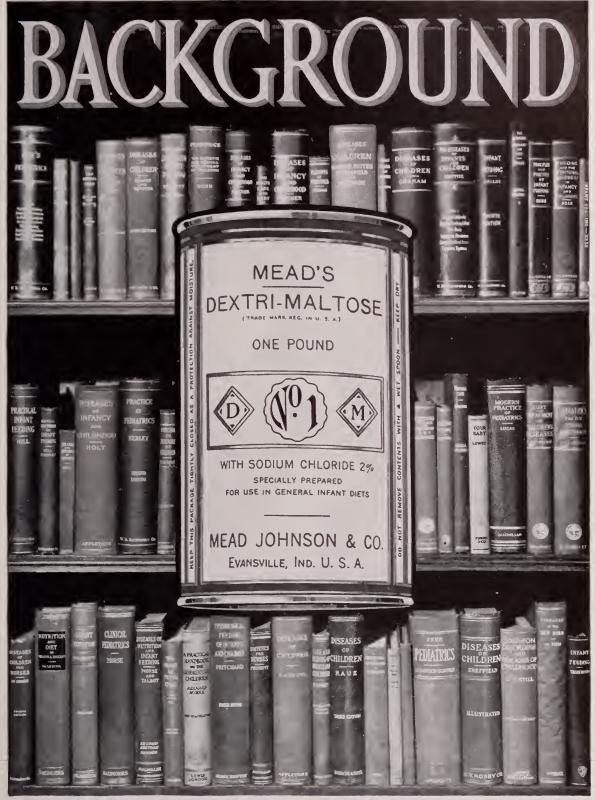
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was asked to serve as Secretary. The President announced that the December party, which had been planned for the doctors of the Duval county society, would be given at a later date and that arrangements were in the hands of a committee. It was voted to renew subscriptions to Hygeia for the Y. W. C. A., the Public Library and the Woman's Club; since the distribution and circulation of Hygeia is one of the Auxiliaries' main projects. A letter from Mrs. Driskell, state president, giving suggestions and ideas for the yearly rogram, was read. Mrs. Herrman Harris suggested that the President send a letter to the President of the Duval County Medical Society, asking that he arge his members to invite their wives to join the Auxiliary. This was moved and carried.

Mrs. Driskell gave a full and entertaining account of the Southern Medical Meeting in New

Mrs. W. S. Manning had the program for the afternoon, which was a most interesting and instructive account of the life of one of our famous Florida doctors, Dr. Joseph Y. Porter, a pioneer in Florida health history and public health.

Following this talk, the meeting adjourned, and delicious refreshments of tea and sandwiches and cake were served.

ADVERTISERS' NOTES

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THE NEXT MEETING
OF THE
FLORIDA MEDICAL
ASSOCIATION
WILL BE HELD AT
SARASOTA
MAY 3-4, 1932

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	Date	Time	ETINGS Place	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	D. M. Adams, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	4th Wednesday	8:00 P.M.	Chamber of Com- merce	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		b
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	7
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday		Tampa Municipal Hospital	No.	
	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	8:00 P.M.	Marianna	No.	
Jackson	W. L. Ashton, M.D.,		3:00 P.M.		Yes.	
Lake	Umatilla. H. Quillian Jones, M.D.,	1st Thursday .	12:30 P.M.	Eustis Lee Memorial		
Leon-Gadsden-	Ft. Myers.	3rd Friday	7:30 P.M.	Hospital	No.	
Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manates	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	Geo. M. Dawson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	Yes.	
Pasco-Hernando- Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
Washington- Holmes						





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THE JOURNAL

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NEXT SESSIONS, FLORIDA MEDICAL ASSOCIATION, SARASOTA, MAY 3-4, 1932

AMERICAN MEDICAL ASSOCIATION, NEW ORLEANS, MAY 9-13, 1932

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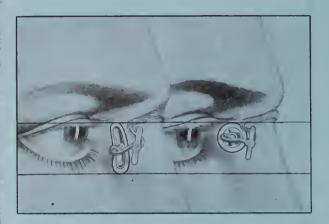
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Number 9

RESULTS OF TRRIGATION AND CLO-SURE IN SELECTED CASES OF NOX-PYOGENIC ARTHRITIS*

Prescott Le Breton, M.D., F.A.C.S. St. Petersburg.

All medical men see at frequent intervals acute infectious arthritis of the ordinary type. Occasionally, the suppurative joint appears with its striking symptoms and imperative need of drainage. Between these types, there is a group of cases of arthritis, usually located in a large joint as the knee or the hip, in which the clinical symptoms are severe, but aspiration shows a clear or slightly turbid fluid, the white count does not indicate suppuration and operation is not performed. The writer desires to report some observations on the treatment of selected cases by incision, irrigation and closure, such treatment being followed by rapid cessation of all acute symptoms.

Type of Case. The history is about as follows: There is usually a preceding recent infection, such as gonorrhea, inflammation of the respiratory tract, or of the pelvis. The onset is sudden and acute, in a large joint, and pain on motion with muscle spasm is marked. Temperature and pulse moderate. Heat, swelling and tenderness, elevated white count not indicating suppuration. Splints, traction, local applications, aspirin, and protein therapy all ineffective. Morphine necessary as any motion causes pain so severe that the patient screams. X-ray at a late date shows arthritis with some erosion of cartilage.

Operation. Under anesthesia, with strict precautions and aseptic technic, a half inch incision is made in a convenient area. At the knee, the incision may be made just inside and above the patella; at the hip, a posterior incision following the direction of the gluteus maximus fibres. For 15 minutes a warm bichloride solution (1 to 15,000) is used to irrigate the joint by glass tube, rubber tubing, and irrigating jar. The joint is slightly distended and then gently emptied until time is up. A final douching of normal salt solution. Sutures, dressing and a light fixation splint or traction. Fluid from the joint shows white shreds of fibrin or flakes of cartilage, and is negative on culture. The surface of the cartilage, as

*Read before the Fifty-Eighth Annual Meeting of the Florida Medical Association, Orlando, May 12, 13, 1931.

seen in the joint, especially at pressure points where bone contacts with bone, shows erosion of cartilage or sometimes red granulations.

If this simple procedure is done early, within four or six weeks, before the inflammation has extended from the synovial sac into the periarticular tissues, the results are often dramatic and are like those following the opening of an abscess. The temperature drops, the pain is allayed, the screaming stops, apprehension at the least movement subsides, and active motion can be instituted as soon as the wound has healed. Partial stiffness and adhesions may persist, which is a very different result from the fibrous ankylosis in deformity that ordinarily obtains.

Besides the five cases reported below, the writer saw a number of similar cases treated at the Buffalo General Hospital by other surgeons with equally good results. The five personal cases represent one elbow, two hips and two knees. Three were of gonococcus origin beyond a doubt and the others were of pyogenic origin. Ages 16 to 66. Final results: Cure with some limitation of motion but good function. Treatment of initial foci left with attending physician.

It is not easy to get consent to do this operation, because there is a fixed belief among general practitioners, nurses and the laity that opening of a joint with loss of synovial fluid means permanent stiffness. It requires prolonged arguments and mental effort to obtain consent for any joint operation in cases of general types. Orthopedic surgeons know from experience how resistant joints are to trauma, and how exact one must be in excising all cartilage from a joint to produce the firm stiffness of an ankylosis. Witness the following types of cases that recover as regards motion, where the capsule has been cut or torn and the joint fluid lost:

- 1. Ordinary dislocation.
- 2. Open operations on fractures running into joints.
- 3. Removal of semilunar cartilages from the knee joint.
 - 4. Biopsy of joint for diagnosis.
- 5. Subcutaneous drainage of joint for chronic hydrops by removal of segment of capsule.
- 6. Retention of function after drainage of suppurative joint, where proper technic has been followed.

- 7. Open operation on congenital hip dislocation.
- 8. Retention of partial function in old tuberculous joints, after cold abscesses have ruptured the capsule.

Literature. The literature is very meager. Many standard text books on orthopedic surgery mention only the open continued drainage of a pyogenic joint. The 2 per cent formalin injection was evolved by Murphy. The prolonged irrigation as outlined above emanated from Boston (Dr. Cotton). Poynton and Schlesinger (1), in their recent work on rheumatism, quote Freiberg as showing that arthritis can occur without bacteria entering the joints, and destruction of cartilage can follow. Churchman (2) uses 2 per cent gentian violet instead of bichloride for both Gram positive and Gram negative infections. Key (3) extolls arthrotomy, irrigation and closure followed by 10 days of plaster cast in cases of gonorrheal arthritis seen fairly early. Porter and Rucker (4) report five cases of gonorrheal synovitis with striking results from the repeated insufflation of air in the knee joint, after aspiration of joint fluid. Enough air is introduced to raise the patella from the femur. This method is well worthy of trial in place of irrigation or could be combined with it. O. L. Miller (5) reports an interesting group of cases of children who had acute transient epiphysitis of the hip joint, in which no suppuration followed. His cases apparently should be classed as osteomyelitis of the neck of the femur of mild type. In the Frank Billings' lecture last summer on the Present Status of Nonspecific Therapy, J. L. Miller (6) admits the failure at times of this treatment, but among the arthritic conditions makes no reference to irrigation.

Comment. Frequently one sees in practice acute arthritis of moderate degree due to toxines from tonsil or alimentary tract. Witness the common shoulder joint of women about 60 years old, or the knee joint in cases of all ages, which yield after some weeks or months of local treatment. Between these cases and those of pyogenic arthritis where there are active bacteria at work, there is the type referred to, distressing to both patient and surgeon, in which the end result is very apt to be ankylosis in deformity. The writer has recently seen three cases of deformed knees with limited motion due to gonococcus infection, giving the usual history of weeks of extreme pain. If irrigation and closure had been done fairly early

the economic and practical results should have been very different.

CONCLUSIONS

- 1. There is a type of acute non-pyogenic arthritis, usually of one large joint, where the symptoms are severe and persistent and the end result bad.
- 2. They are not relieved by ordinary measures of splinting, traction, physiotherapy or foreign protein therapy.
- 3. Irrigation and closure at a fairly early date promises immediate relief of symptoms and a much better end result.

CASE REPORTS

- 1. R. C. female, aged 16. Examination, July 18, 1927. Following her marriage, two months before, this girl developed gonorrhea, and four weeks afterward her left knee became swollen and painful. There had been fever, loss of weight, and extreme pain. Pulse 120. Distention of knee joint with fluid so that the tape showed an enlargement of almost two inches. Heat and tenderness. Motion from short of full extension back to a right angle. X-ray showed arthritis. On July 19 at the Buffalo General Hospital the joint was irrigated and all acute symptoms rapidly subsided. When last seen, on August 27, her recovery was almost complete.
- 2. W. W. D., married female, aged 26. Some weeks before her first baby was born, on July 11, 1928, her husband infected her with gonorrhea. In late June the left knee joint became swollen. She remained in bed on account of extreme pain which necessitated morphine, and had had much treatment, including vaccines. On consultation, August 13, 1928, with Dr. Rich, the patient was found to be worn out with prolonged suffering. Temperature normal. The left knee joint was a dusky red color, hot, tender and indurated. The tape showed two inches enlargement. Motion in a flexed position of 10 degrees possible, but this caused screams. X-ray showed arthritis with roughened joint surfaces between knee cap and femur.

On August 17 at the Buffalo General Hospital irrigation was done. Patches of red granulations appeared on the cartilage. Adhesions were loosened until the joint moved from full extension backwards 45 degrees. Plaster back splint. August 21, complete relief of subjective symptoms. August 28, cast off; marked improvement in joint. September 7, 20 degrees motion. October 26, walked a little. Induration still caused seven-

eighths of an inch enlargement. Motion from 10 degrees short of full extension back to 40 degrees. Continued improvement under physiotherapy. One year later, good function with limited extension. This case was headed for ankylosis in flexion.

Case 3, A. L. male, aged 66. Examination at the Columbus Hospital, Buffalo, October 15, 1929. Previous history negative. For some weeks he had had a swollen, extremely painful left elbow. Fever about 101 daily. Whites 13,000. Wassermann 4 plus, for which he was receiving treatment with no effect on the elbow. The joint was boggy and excruciatingly painful over the head of the radius. Flexion and extension fair, pronation and supination very limited and painful. X-ray negative. October 18, irrigation with incision over the radius. Fluid flocculent. Head of radius showed a gouged out eroded area for one-third of its circumference. November 14, comfortable with no temperature. Culture of fluid from joint negative. Later, recovery with some limited motion.

Case 4, male, aged 18. Examined in Jamestown, N. Y., by Dr. Barone, May 31, 1930. This young man contracted gonorrhea some eight weeks before and promptly developed arthritis, slight in several joints, but extreme in the right hip. Temperature often 103 or 104. Loss of weight. Hemoglobin 50 per cent and whites 12.000. Pain so violent that an anesthetic had been used to apply traction, which was ineffective. The joint did not appear swollen, but was very tender, and the patient was apprehensive of the slightest movement. X-ray negative. No count had been made. Irrigation by Ober incision at once at the Jamestown Hospital. Joint fluid not much increased, but turbid. Cartilage on the head of the femur looked like raw steak. Traction reapplied. This case was lost track of by the attending physician and no later record obtained.

Case 5, female, aged 26. Examined June 11, 1930, at the request of Dr. Getman. After the birth of her second child, on April 14, she developed puerperal sepsis (strep. hemolyticus). A stormy course with three blood transfusions. Then a thrombo-phlebitis of the pelvis. With apparent recovery she went home from the hospital, and then developed three weeks before examination by the writer acute arthritis of the left hip joint. No relief from violent pain except by morphine. Low fever and extreme anemia. examination there were found fullness along the trochanter, tenderness, great apprehension on attempting to move the hip joint. She was removed to the Buffalo General Hospital, where the X-ray showed arthritis with smeary, irregular contour of the upper part of the head of the femur.

June 12, Ober incision and irrigation. Flakes of cartilage in the joint fluid. Head of femur rough with reddish spots. Traction, June 25, home. No pain or fever since operation. Wound healed. July 22, about on crutches. Free motion without pain. Later on, good function.

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DISCUSSION

Dr. F. L. Fort, Jacksonville:

Anything that offers us any additional weapon or any advancement in the treatment of arthritis is worthy of our serious consideration. Certainly if you will read the literature you will appreciate how confused our present state of terminology, etiology and treatment is in regard to arthritis.

It is impossible to discuss the whole subject of arthritis, and I think Dr. LeBreton is very wise to confine his paper to a very select group of cases, and probably one that is as much neglected or improperly treated as any other type.

Fortunately, this particular type of acute, nonsuppurative, monarticular arthritis is not so very frequent. It results many times in long drawn out periods of disability, loss of motion, and deformity, besides considerable pain and financial loss.

I am firmly convinced that Dr. LeBreton is advocating a method that will shorten the period of treatment, help relieve the pain to the patient, and also give us practically a normal joint if the cases are properly selected.

I would like to say just one word about selecting cases. The greatest danger, in my opinion, is in letting them go too long, until the infection has become imbedded in the soft tissues around the joint and the synovial membrane is three or four times as thick as normal. It is too late then. But if we take these joints early, before the synovial membrane has become so thickened, we can sterilize it by washing it out and, therefore, stop the process before the joint is destroyed or the blood stream involved.

Now, for several years we have been in the habit of opening purulent arthritis as soon as we recognize it as being purulent. If there is any doubt about it, I have no hesitancy in aspirating the joint. I make incisions and counter incisions for free drainage. That is doubtless the best treatment, in my opinion, for suppurating joints. And in these cases I use a continuous irrigation for a day or two longer. Dr. LeBreton aims at aborting the infection before suppuration occurs.

Whether or not it hurts to open, irrigate, and sew up an infected joint in the early stages, only experience can tell. In my opinion, it is the one best thing to do. I am satisfied from the limited number of cases in which I have had an opportunity to use the method advocated by Dr. LeBreton that it is a short cut, most pleasing to every one concerned in handling these selected cases of monarticular non-pyogenic arthritis.

Dr. Prescott LeBreton, St. Petersburg (concluding):

I wish to think Dr. Fort for his discussion. I fully agree with everything he said. I omitted several paragraphs to save you people time. I thank you.

SOME OBSERVATIONS ON THE TREAT-MENT OF EMPYEMA OF CHILDREN BY ASPIRATION*

ALVYN W. WHITE, M.D., Pensacola.

During the past fifty years, no surgical condition has aroused more discussion than the treatment of empyema. We have the advocates of both types of procedure, namely, the insertion of a tube in the plural cavity, and aspiration. This controversy signifies the fact that neither method is considered satisfactory because in each the mortality seems greater than it should be. Empyema was known to the ancients and the importance of drainage recognized by Hypocrates, but the best method of obtaining this drainage is still a much mooted question. Roe, in 1844, was the first to employ paracentesis as the sole means of treatment. Before the Royal Medical Society of London he reported nine cases of empyema using aspiration, with one death. Henry Bowditch was the first to sponsor aspiration in this country. In 1910, Holt reported a series of 139 cases of empyema treated by aspiration alone; twenty-five were cured, thirteen died, and one hundred and one underwent subsequent operations. A strong contrast to Roe's series is Kassowit's, who treated a total of fifty cases by rib resection, three of which died. Scott, some years later, lost ten of twenty-six cases treated by operations. The cause of this discrepancy in results, both in aspiration and rib resection, is unexplained. Whatever it is—technique, selection of cases or whatnot—it only substantiates the fact that neither procedure can be considered the method of choice.

In 1928, at the suggestion of Dr. Joseph Brennemann, Dr. E. T. McEnery used aspiration as the means of treatment in all cases of empyema at Children's Memorial Hospital, except the following five:

- 1. A child with a post-operative fistula and a drainage tube lost in the empyema cavity.
- 2. One case with an aspirating needle lost in the cavity before admission.
- 3. An infant who anticipated aspiration by coughing up the pus, and getting well by himself.
- 4. One operated on at the insistence of the attending physician.
- 5. One because of natural anxiety at the beginning of the series.

The total number of admissions was thirty-seven. Of these, thirty-two were treated by aspiration. McEnery states that all are now well as far as can be determined both clinically and by X-ray, except the following:

- 1. One died of pneumococcus septicemia and meningitis.
- 2. One left the hospital against advice and died two weeks later.
- 3. A patient with a severe case of pneumonia followed by an extensive empyema was morbid and cynotic, considered in no condition for operation by the surgical staff. Aspiration was tried and a total of 3,635 cc. of pneumococcus pus was removed in ten aspirations. The patient expired and 1,110 cc. of pus was present at autopsy.

One patient was to go home and return for aspiration. He was not seen again. It is understood that he still has his empyema and a bronchial fistula.

McEnery's mortality was 9%, including the case of meningitis; 6% if this case is excluded.

Cultures of the pus showed 28 pneumococcus, 3 streptococcus hemolyticus and 1 staphylococcus albus.

This paper is not intended to advocate any procedure in the treatment of purulent effusions, nor is it a statistical report. Having aspirated or ob-

^{*}Read before the Escambia County Medical Society, Pensacola, November 10, 1931.

served and followed some twenty-odd, unselected cases of empyema during the year of 1929-30, it is my intention to present some interesting happenings not in accord with the accepted facts concerning this line of treatment.

The following method of procedure was used: Under sterile technique, a large bore aspirating needle was inserted between the ribs at the desired location, 1% novocaine being used as an anesthetic. About 6 inches of rubber tubing was attached to the needle over which a hemostat was clamped. When pus was located, it was removed by connecting to the rubber tubing a 50 cc. Luer syringe or a suction apparatus. The fluid seemed to run more freely after the first aspiration. Fibrin clots, while bothersome, did not hinder the procedure to any extent. Cultures were taken at the first aspiration. X-ray pictures were made before and following each aspiration. The site of insertion was determined by the X-ray, physical findings, and, if necessary, by the fluoroscope. There was no rule concerning the frequency of aspiration or the amount of fluid removed at each attempt. The individual patient guided us in this. As a rule, a rise in temperature and loss of appetite plus other physical findings were indications for paracentesis. The number of aspirations varied, the average being about five.

Observations: The age of the child seemed to play an important factor in determining the method of treatment. The mortality under three years is notoriously high. Spence reports a mortality of 45% under three years; Cameron, 75% under two years; Holt, 72% in the first year, 52% in the second year. McEnery, using aspiration in a total of 32 cases, with a mortality of 9%, had 50% of his paitents under three years of age, of which 30% were under two years, and 12% under one. It would seem that children under three years do better by aspiration than an open operation, and that they fare better than older children.

Empyema did not seem such an emergency as is sometimes thought, nor did all the pus have to be evacuated before recovery. As mentioned in the procedure, we did not have any hard and fast ru'e about aspirating, and in most cases tried to put it off as long as possible. The general condition of the patient, of course, determined this. Small empyemas, if let alone, will cure themselves, but one was impressed with the large amount of pus that nature could take care of. We were not hindered much by fibrin clots, which was one of Holt's objections to aspirations.

On looking over the X-rays, one is surprised

to note a large number of pyopneumothoraxes sometimes occurring during the treatment. A conservative estimate can be placed at 50%. We took no special pains to guard against this, and at times would force a small amount of air into the plural cavity, noting that the pus would run more freely. Most of the pyopneumothoraxes could not be determined clinically but were picked up by X-rays. There were no disturbing symptoms. It was suggested that the stay in the hospital was longer with pyopneumothorax. This was not my observation.

Bronchial fistula in patients with a pyopneumothorax seemed to hasten recovery by coughing up the pus. There were no permanent fistula cases noted. One case is of interest. A boy, aged seven, diabetic, developed pneumonia of the right lower lobe, followed by empyema. Because of his general condition, it was thought that open operation would be the method of choice. However, he was aspirated once, and 175 cc. of pneumococcus pus were removed. We intended to insert a tube the following day. Twelve hours later he coughed up a large amount of pus, a bronchial fistula having developed. Operation was deferred. He continued coughing up pus for several days, and recovered without further drainage.

Local cellulitis around the site of aspiration was rare, caused no alarm and cleared up promptly under hot boric dressings. No serious complications were encountered during aspirations. The pus was frequently blood-tinged, but we came to regard this as of no importance. Emphysema of the tissues surrounding the wound occurred, but subsided in a few days. One case is of sufficient interest to mention. A boy, aged nine years, with a diagnosis of empyema was aspirated three times, once under the fluoroscope, but no pus was obtained. All punctures were made in the right lower lobe posteriorly at the angle of the scapula. The physical signs were not pronounced. Dullness seemed to shift to the anterior wall, and a needle was inserted in the fourth intercostal space to the right about eight centimeters from the midline, and 150 cc. of pneumococcus pus were removed. Twenty-four hours later he developed an extensive emphysema of the body, neck and face. He was acutely ill, and the outcome seemed questionable. Pressure was applied over the aspiration wound. He began to improve after three days. The emphysema disappeared in a few weeks, and he was aspirated again without further trouble. The patient recovered.

Empyemas due to organisms other than pneu-

mococcus seemed also to be benefited by aspiration. Although pneumococcus was the most common type found, streptococcus hemolyticus and staphylococcus were also the causative agents in several cases.

Comment: No attempt is made to give statistics, mortality rate, etc., on the twenty cases observed, as they are a part of a series of 98 cases to be reported in the future. General observations are all that are attempted in this paper. No intention is made to advocate aspirations as the method of choice in the treatment of empyema. One would not be justified in making so dogmatic a statement. If we consider empyema as not an emergency it would seem logical in the light of recent work to try aspiration in children under ten or twelve years, and then resort to operation, if necessary. Wilensky, in 200 cases, reports a lessening mortality with each week operation is deferred. In infants, it appears to be the method of choice. Why infants do better by aspiration is not quite clear. Less pus and a small cavity to obliterate may play some part. Recent statistics seem to show a marked lowering of the mortality rate in children under four years using aspiration as the means of treatment.

CONCLUSIONS

One can make no definite conclusions from this presentation. The results obtained by aspirating infants seem the most encouraging. This work is being carried on, and we can only hope that the controversy will be cleared up some time in the future. It is almost certain that other factors besides a purulent effusion will determine the best method of approach.

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DISCUSSION

Dr. J. M. Hoffman, Pensacola:

I concur with Dr. White in his observations as stated in his paper. I feel that the subject is very timely. In the past, empyema has been regarded as practically an emergency as soon as definitely diagnosed. The old rule of evacuating pus as soon as found does not hold true in empyema. An excellent symposium was reported in a recent issue of Surgery, Gynecology and Obstetrics, on this subject. All methods of treatment were advocated by some. I believe the consensus of all opinions was to wait for definite localization of pus and for a suitable physical condition of the patient, particularly so in those cases of streptococcus hemolyticus empyema. I had the good fortune some several years ago, to work with Dr. J. A. Danna, of New Orleans, in treating a large series of empyema cases by aspiration. His method was to replace the aspirated fluid by a like volume of air. In a large percentage of these cases, no open operation was necessary. The mortality was practically nil. This method has the advantage of allowing a complete removal of the fluid from the chest, and eliminates the shock attending a sudden release of the intra-thoracic pressure. The air is soon absorbed. I had occasion to see this method demonstrated to advantage in a case of my own recently. The child on admission, was gravely ill with a right empyema. Aspiration revealed a watery purulent fluid. Streptococcus hemolyticus was found. The child was aspirated and fluid volume replaced with air for several consecutive days, with marked improvement in general condition. The child was then allowed to go home, to return to the office every week for aspiration. After several weeks, a trocar and canula was inserted between the ribs, and a closed catheter drainage was established. The catheter remained in situ for one week, and the child made an uneventful recovery. I believe that the time of emergency thoracotomy for empyema has passed. The aspiration method should be used first, and open operation can always be done later. I fee! that our mortality rate will be lessened thereby.

Dr. J. H. Fellows, Pensacola:

I agree with Dr. White and Dr. Hoffman that we should not be in too big a hurry to operate on an empyema case. We should wait until the pus is well formed and adhesions have become established.

Dr. C. J. Heinberg, Pensacola:

I would like to ask Dr. White if the pneumococcus organisms in his series were typed. I had occasion in New York recently, to see some work done on the aerobic and anaerobic organisms. Necessarily, the injection of air would be contraindicated where organisms are present that thrive in a high oxygen content. It was my impression that Type III pneumococcus was such an organism.

Dr. J. S. Turberville, Century:

I have often wondered at the high mortality rate in empyema as reported in our medical journals. In my own experience, the mortality rate has been very low. Of course my cases are usually well advanced, and hence I have had excellent results with the open operation. In my mind, the tube drainage is bunglesome and prolongs convalescence. I believe if we are careful and take our time, that no shock will follow and results will be good. Wait until adhesions form. I do not feel that we should at this time take sides in attesting to the ideal treatment and that we should gather more statistics and data before rendering any definite opinion. We see comparatively little empyema in the south, and I am sure that our mortality rate is much lower than in the northern and eastern clinics.

Dr. A. W. White, Pensacola (closing):

Infection with the streptococcus hemolyticus is considered by some the one contraindication of the treatment by aspiration. In the cases reported, six of these were aspirated and all recovered. In conclusion, I would like to emphasize that the treatment of empyema is not an emergency measure, that we should first aspirate, and later, tube drainage can be established if necessary.

THE ESSENTIAL NATURE OF BRON-CHIAL ASTHMA AND ITS PRESENT-DAY MANAGEMENT*

KENNETH PHILLIPS, M.S., M.D., Miami.

I should like to introduce my paper with a few brief statements which are absolutely basic. First, it is claimed that bronchial asthma can now be managed by a definite routine and program which will yield the same assurance of success as in other common diseases of known etiology; that unless this management insures a close working harmony between the internist and rhinologist in every case it will almost surely fail; and, third, that the management herein advocated does in no way denounce or discard the allergic theory, but envelops it and places it on its proper stool along with the other symptoms of the asthmatic syndrome.

Little or no good purpose can be served by

*Read before Polk County Medical Society, Bartow, October 14, 1931.

devoting space to further additions of the speculative or controversial literature because reviews of the literature are of little value except in making clear the prolonged helplessness of the profession before the problem.

That this helplessness remains unmodified can be amply shown by reference to the voluminous literature published each year, and by review of editorials from the leading medical journals of this country and Europe for the past few years, the bibliography of which I present here for convenience of those who might wish to review them. I shall therefore confine the balance of this short paper to a discussion of a conception and a management of asthma which has stood the test both clinically and experimentally, but which is altogether too little understood and in many quarters still unheard of.

Over thirty years ago, investigations in bronchial asthma were beginning in three different parts of the world. They were carried on simultaneously, but no one investigator knew of the others. After many years, by strange and devious paths, these three pieces of work became united into one harmonious whole.

In Glasgow, Scotland, James Adam, a lone investigator, started a clinical study of this disease and in 1900 wrote a thesis in which he put forward the view that asthma was a result of two underlying basic factors, a general systemic toxemia, and a lesion in the upper respiratory tract most commonly the nose. These ideas were elaborated in his post-graduate lectures at Glasgow in 1910, and in 1913 he published a book which somehow was lost sight of and was placed by the wayside for years, only to be resurrected chiefly through the attention heralded it by Haseltine in America. In 1927 it was re-edited and now receives the compliment of no less an authority than Chevallier Jackson, "the most helpful book ever published on the subject."

In 1903, Brodie and Dixon, two European physiologists, presented before the Pathological Society of London the results of a carefully planned scientific animal experimental study on bronchospasm and definitely proved a neuroanatomical connection, reflex in character, between the bronchioles and sensory nerve terminals of the upper respiratory tract, the most sensitive and predominant receptive area being the ethmoid area of the nose. The unqualified statement "definitely proved" is based on animal experimental work covering the past two years, the result of which as yet has not been published. The work of Brodie and Dixon, after being exposed

to modern physiological analysis and criticism, has been repeated, confirmed, and by use of this together with the utilization of the toxic factor, the chest condition has been produced in the living animal.

Unaware of the work of Adam, or that of Brodie and Dixon, Burton Haseltine, of Chicago, some twenty-five years ago began investigating and slowly weaving the results of his studies and observations into a logical construction for the basis of asthma. Insofar as I am able to find, he was undoubtedly the pioneer who carried the banner for America in this development. As time went on he was joined by La Forge, Waterman, Fitzpatrick, Kern and others, all specialists in their various branches.

After nearly a quarter of a century came the time for reckoning and it was found that the separate investigations in three different parts of the world had independently come to the same conclusions. About five years ago they met across the water; they devised and revised what seemed necessary and compounded one of the most val-Their docuable pieces of work in medicine. trines are here to stay because a check-up at random reveals among the well-trained and equipped physicians personally known to the writer, a list of over fifty scattered throughout this country and Europe who have attained a proper understanding of the technique, and who are unanimous in their testimonies, based on well-seasoned, clinical trial, that we can now handle the asthmatic with a precision and mangement yielding results the same as in other diseases of known etiology. There is also the refreshing fact that in the therapy of these cases nothing need be done that would not be indicated for the physical welfare of these patients even though they were not asthmatic. For those who thrive and insist on figures, it can be said in passing that the total number of cases involved are between 3,000 and 4,000, and these are not selected cases but are consecutive asthmatics as they have appeared.

First and foremost in this conception of the nature of asthma, is the fact that all of these patients are systemically abnormal. They have undergone a general systemic upset which these investigators have termed a toxicosis. Whether the patient falls into the allergic or non-allergic group makes no difference; he is still a toxic patient. The origin of this upset condition or toxic state may be bacterial or non-bacterial; it may be exogenous or endogenous; the mere dysfunction of the natural channels of elimination may produce it. Nevertheless, it must be found and

must be corrected and this automatically drafts into service the cooperation and ability of any and all branches of medical practice.

This upset condition or toxic state is no imaginary thing but is a definite condition which has been shown by the work of Mitchell, La Forge, Ellis of London, Cameron, Ashby, Kern, Maxwell and Phillips in the blood and urinary studies of these cases.

Among the various things which this toxic condition might produce is a hyper-irritability of the nervous system with a corresponding change in the nervous threshold. Once this is produced, the patient is in a receptive mood for the second underlying factor brought out by the investigators, namely, an irritative lesion somewhere in the upper respiratory tract, the most common and predominant area being the ethmoid region of the nose. This irritative lesion may vary from a simple foreign body or contact points by bony deviation up to a degenerative polyposis or sinus empyema.

What more concrete and logical concept, based upon both clinical and experimental investigation and seasoned with twenty-five years of clinical trial, has ever been placed before the medical profession than that regarding the asthma problem?

To institute proper treatment those specialists in whose lot it falls to be entrusted with the proper management of the upper respiratory tract must have a thorough understanding of this basic conception plus an acquired thorough technique. The utmost cooperation between the internist (pediatrician in cases of children) and the rhinologist is necessary.

The details of management are so elegantly and concisely described in a symposium published in the Medical Journal and Record, November 6, 20, 1929, and again in the Eye, Ear, Nose and Throat Monthly, June and July, 1931, that I need only to outline them.

The primary duty of the internist is to find the origin of this toxicosis and correct it. It will frequently be necessary for him to draft into service the skill of any specialty or branch of medicine or dentistry. Elimination through the four natural channels by the judicial use of physical and natural means, so adequately described by La Forge in the above symposium, should constitute a commandment in the armamentarium of every internist for its value in dealing with every sick patient whether or not he be asthmatic. Dietary blunders, described by Adam, should make us all wonder how so many people can escape the

physician and the hospital. Those words of caution and warning, so ably dished out by Haseltine and Myers, to "restore but not destroy" must certainly ring in every medical man's ears who has dealt with a large group of asthmatics and has looked into their noses. By the utilization of the Dowling intranasal tampon, ingeniously modified by Haseltine, it becomes possible to save scores of these poor victims from radical, destructive, and many times permanently harmful mutilating surgery. This alone should be incentive enough for a complete investigation of the facts by any rhinologist.

These facts are now so well established that any time spent in argument about them is time wasted. The need now is to make these methods available to the deplorably large number of sufferers who are not obtaining relief. This can only be done by close affiliation between the internist or general practitioner and the rhinologist in each and every case and each must have some special training in the treatment of asthma by this program. Unless this is acomplished, experience again cautions that a well-tested management will fail due to a lack of thorough skill on the part of the managers.

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FOREIGN BODIES IN THE FOOD AND AIR PASSAGES—REPORT OF ONE HUNDRED CASES*

WILLIAM JEROME KNAUER, M.D., F.A.C.S., Jacksonville.

In previous papers, I have written fully about the history of bronchoscopy and the diagnosis of foreign bodies, so in this paper I shall only outline a few of the important facts gathered from one hundred cases taken at random from my records. I can not refrain from again especially appealing to pediatricians to stress the importance of instructing their little patients to keep play objects out of their mouths; to appeal to the mothers to not leave open safety pins near their babies; to beg physicians in general to send their cases early to an endoscopist and not to fail to have an X-ray and thorough study made.

As we shall see in the cases to be presented, there were thirty-five in which the foreign body had been in longer than two days, without having anything done. With the automobile and aeroplane, this is certainly unnecessary. An important fact which the following cases emphasize is that regardless of all previous X-rays, another X-ray should always be made before operation for it is surprising how frequently foreign bodies change their position. I have also found that the frequent use of atropine hypodermatically following bronchoscopy will save many a tracheotomy. In the removal of foreign bodies, I have used local anesthetic only, with the exception of one case. (Atropine only is used in children one hour before operation.) In the three deaths which are reported two followed the removal of a peanut. These patients had had a tracheotomy and were progressing satisfactorily when suddenly, three days following the tracheotomy, they died. the other case, a chicken bone ruptured into the mediastinum in a patient who already had a mediastinitis. I removed the bone but the patient died thirty-six hours later.

Too much cannot be said about having the full cooperation of the internist, surgeon, and roent-genologist and about having trained skilled help and proper equipment. Last, but not least, the bronchoscopist must constantly practice, the same as any skilled musician, if he is to be proficient in his work. After all, the final result lies in his ability to see and to use his hands and fingers properly.

In compiling the statistics, I found fifty-two cases in females and forty-eight cases in males, ninety-two white patients and eight negroes. There were thirty adults and seventy children.

The foreign bodies were distributed as follows: two in the pharynx, forty-eight in the esophagus, nine in the trachea, twenty-three in the right bronchus, ten in the left bronchus, four in the larynx, three distributed in the right and left bronchi and one in the trachea and bronchi. Among the complications were: rupture and collapse of a lung following a large abscess near the base of the lung; and a lung abscess and bronchiectasis following the removal of a peanut. Intubation had to be done in one patient following the removal of a diphtheretic membrane from the lower trachea and bronchi.

The following summary of each case has been so arranged that the salient features of each classification of foreign body are apparent at a glance and to emphasize the main points which may help in the next case of the same kind.

^{*}Read before Riverside Hospital Staff.

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
5-131	3 yrs. Male Colored	Fish bone	Beginning esophagus 2 weeks	None	5 mm.	31 min.	Recovered	There were two large papillomas of vo cords, which I had to remove before co enter trachea.
V-69	35 yrs. Female White	Fish bone	Right pharynx 24 hours	None	Short esoph.	1 min.	Recovered	
T-216	38 yrs. Female White	Fish bone	Midway esophagus 24 hours	None	7 mm.	30 seconds	Recovered	
V-205	19 yrs. Female White	Fish bone	Beginning esophagus 4 hours	Local	Short esoph.	1 min.	Recovered	
W-233	18 yrs. Female White	Fish bone	Beginning esophagus 1 hour	None	Short esoph.	4 min.	Recovered	
V-214	42 yrs. Male White	Fish bone	Beginning esophagus 12 hours	None	Short esoph.	2 min.	Recovered	
K-504	39 yrs. Male White	Fish bone	Upper esophagus 1 hour	None	10 mm.	2 min.	Recovered	
R-338	30 yrs. Male White	Fish bone	Upper esophagus 2 days	Non€	7 mm.	5 min.	Recovered	
W-363	24 yrs. Female White	Fish bone	Beginning esophagus 5 days	None	Short esoph.	3 min.	Recovered	
K-308	20 yrs. Female White	Fish bone	Midway esophagus 2 days	None	7 mm.	3 min.	Recovered	
T-276	28 yrs. Female White	Fish bone	Beginning esophagus 12 hours	None	Short esoph.	7 min.	Recovered	
R-532	50 yrs. Male White	Fish bone	Midway esophagus 1 day	None		4 min. 30 sec.	Recovered	
R-359	21 yrs. Male White	Fish bone	Upper esophagus 8 hours	None	7 mm.	2 min.	Recovered	
R-21	48 yrs. Male White	Fish bone	Beginning esophagus 4 hours	None	Laryn- goscope	1 min.	Recovered	,

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
R-520	7 yrs. Male White	Sandspur	Right bronehus 1 days	None	5 mm.	m.n.	Extraction and cure	
T-140	6 yrs. Female White	Sandspur	2 hours	None	5 mm.	5 min.	Recovered	
F-363	12 yrs. Male White	Sandspur	Trachea 1 hour	None	7 mm.	4 min.	Recovered	
V-59	6 yrs. Male White	Sandspur	Trachea 6 hours	None	5 mm.	nin.	Recovered	
W-339	16 yrs. Male Colored	Sandspur	Left bronchus 21 hours	None	7 mm.	5 min.	Recovered	
S-140	3 yrs. Female Colored	Sandspur	Trachea 7 days	None	5 mm.	7 min.	Recovered	
R-521	7 yrs. Female White	Sandspur	Larynx 2 hours	None	Laryn- goscope	3 min.	Recovered	
R-128	10 yrs. Male White	Sandspur	Trachea	None	7 mm.	5 min.	Recovered	
R-501	2 yrs. Male White	Sandspur	Larynx	None	Laryn- goscope	6 min.	Recovered	
R-522	8 yrs. Female White	Sandspur	Lower trachea 4 hours	None	7 mm.	11,2 min.	Recovered	
G-367	35 yrs. Female White		Vocal cords	None	Laryn- goscope	10 min.	Recovered	

Record No.	Age	Foreign Body	Location	Anes-	Tube	Time	Result	Comment
T-31	2% yrs. Female White	Fish bone	Beginning trachea and vocal cords		Bronchus 4 mm.	2 min.		Child very hoarse when brought in and ha difficulty in hreathing. After bone was removed, the breathing immediately change from a labored one to a quiet one and the voir returned to normal. The child went hom and felt fine for three days. On the night of the fourth day she developed a very croup respiration with some cyanosis. I at one thought of diphtheria but there was not membrane and the smear was negative. An other bronchoscopy was done, which showed only a laryngeal edema. The child was puto bed and in three days had complete recovered. This case illustrates how can fully a bronschoscopic patient has to had watched, even after the removal of a foreighody.
R-517	16 yrs. Male White	Sandspur	Cardiac end of esophagus 6 days	None	10 mm.	1 min. 40 sec.	Recovered	Football player.
R-591	40 yrs. Male White	Fish hone	Beginning of esophagus 1 day	None	Laryn- goscope	3 min.	Extraction and cure	
K-457	43 yrs. Male White	Fish bone	Pharynx 4 hours	None	Laryn- goscope	1½ min.	Extraction and cure	
R-339	51 yrs. Male White	F'ish bone	Mid- esophagus 1 day	None	10 mm. esoph.	9 min.	Extraction and cure	
V-380	34 yrs. Female White	Chicken bone	Midway esophagus 1 hour	None	7 mm. esoph.	30 min.	Extraction and cure	
V-244	62 yrs. Male White	Chicken bone	Esophagus 2 hours	None	10 mm.	2 min.	Extraction and cure	Bone was wedged in esophagus with wiend down. It had to be turned in two directions before it could be removed.

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
V-205	67 yrs. Female White	Chicken bone	Beginning esophagus 16 hours	1-	Short csoph- ago- scope	2 min.	Death	I saw this case one hour after it occurred but she refused esophagoscopy. She was warmed of the danger of waiting but said that she would take the risk. Fifteen hours later she came in with a mediastinitis. I esophagoscoped her and recovered the bone. She was fed rectally but the mediastinitis gradually grew worse and she died thirty-six hours later.
R-595	25 yrs. Female White	Cartilage of chicken bone	Right bronchus several months	Local	7 mm.	9 min.	Extraction and cure	Constant cough for a period of five months.
	27 yrs. Female White	Chicken bone	Lower esophagus 2 hours	None	10 mm.	8 min.	Extraction and cure	Much food had to be removed before bone was located.
R-563			Beginning	Local	Short	10 min.	Extraction	This piece was so imbedded that two
W-313	32 yrs. Female White	Cartilage of chicken bone	esophagus 1 hour	Local	esoph- ago- scope adult size	TO HIHE.		attempts had failed to dislodge same. The third attempt was successful.
S-383	2 yrs. Male White	Five small hog bones	Left bronchus 2 weeks	None	5 mm. bron- cho- scope	25 min.		The child was brought into the hospital in a very weak state, with a high temperature, fast pulse, laryngeal edema and congestion of the left lung. The child had repeatedly heen put off by another bronchoscopist until the superintendent advised them to call us. Upon removal of the hones, which had to be gotten one at a time, the child made a complete recovery. The history is unique in that the child was chewing on a hog bone when he was suddenly frightened by a running hog and aspirated the bone.
T-450	11 mos. Female White	Quail bone	Trachea 5 days	None	5 mm.	11½ min.	Extraction and cure	
V-73	76 yrs. Female White	Piece of spare rib	Beginning esophagus 12 hours	None	Short espoh- ago- scope	7 min.	Extraction and cure	
W-307	46 yrs. Male Colored	Piece of beef and gristle	Cardiac end of esophagus 24 hours	None	10 mm. esoph- ago- scope	5 min.	Extractionand cure	This piece of meat and gristle had to be taken out in separate pieces. Only the gristle was saved.
	60 yrs. Male White	Pork bone	Midway esophagus 3 days	None	10 mm.	12 min.		Had to remove about two ounces of food hefore bone could be located.
5-5		ļ						

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
W-367	4 yrs. Male White	bead	Base of right bronchus 1 week	None	5 mm.	5 min.	1	This case had had two bronchoscopies before being sent to me. The first bronche scopic examination revealed a large lun abscess at the base of the right lung with bead at its base. As the child was in sue poor shape, we merely drained the absces and waited a few days in hopes of his physical condition improving. The second bronch scopy revealed no improvement in the abscess, so it was drained and the beag grasped; just as I reached the vocal cord the bead slipped off the forceps. Followin this, there was a collapse of the lung with rupture of the abscess into the pleural caviand an emptying of the bead into the pleural cavity. Several days later the childveloped a pneumonia. As this cleared, pyopneumothorax developed and a thoractomy was performed. Three weeks lat fleuroscopy showed the bead at the entran of the thoracotomy wound, where it we grasped with a pair of forceps.
S-156	19 yrs. Female White	Rubher Irain	Lower left bronchus posteriorly 9 years	Local	7 mm. bron- cho:cope	15 min.	Did not recover	Sixteen days following bronchoscopy, t drain was removed externally by a surgeo The patient was making a splendid reco ery when ten days after the operation s had a sudden hemorrhage from her wou and lung and died. The rubber drain w left in from a previous rib resection a had partly worked itself into the lung.
S-385	5 yrs. Male White	Diphtheritis membrane in lower trachea and bronchi	Trachea and bronchi	None	5 mm.	5 min.	Cured	This patient had been hoarse and had helpstight dyspnea for a week before I saw his Examination of the vocal cords reveal them slightly reddened. Two cultures we negative for diphtheria. X-ray was sucious of a nonopaque foreign body. Brond scopy was performed and a membrane moved from the lower trachea and brond Smear showed diphtheria. The child we given 30,000 units of anti-toxin, intubat two hours later and gradually recovered.
W-176	19 mos. Male White	Foil off kodak film	Right bronchus 4 days	None	4 mm.	10 min.	Extractio and cure	This case gave a definite history of as ating a foreign body, although X-rays two different cities, revealed a chest negat for a metallic foreign body. It was the sistence of a pediatrician in a city do state that brought the case into my han X-ray by Dr. Shaw revealed pathology the chest, but showed no metallic fore body, such as tin foil. We were all sprised when quite a large piece of foil recovered through the bronchoscope. Hever, further investigation showed that particular piece of foil was non-opaque, was found that film covering kodak is mo faluminum and is non-opaque.
W-65	8 yrs. Male White	Small end of paper horn	Right bronchus 6 hours	None	5 mm.	6 min. and 8 min.	Extractio and cure	
V-274	3 yrs. Female White	Cap of 22 car- tridge	Right bronchus 12 hours	None	5 mm.	4 min.	Extraction and cure	

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
R-342	1 yr. Male White	Water- meion seed	Hard palate 3 weeks	None		11 ₂ min.	Extraction and cure	The watermelon seed resembled a growth of some sort. The family doctor had a Wassermann taken and two ear, nose and throat men proclaimed it a growth.
R-10	2 yrs. Male Colored	Water- melon seed	Right bronchus 6 weeks	None	5 mm.	8 min.	Extraction and cure	Vocal cords very edematous for 24 hours.
	11 mos. Female White	Water- melon seed	Right bronchus 30 hours	None	4 mm.	7 min.	Extraction and cure	
W-14								8
R-578	13 mos. Male White	Coffee bean	Left lower bronchus 12 days	None	5 mm.	31 min.	Extraction and cure	Baby was chewing the coffee bean, when it was suddenly frightened and aspirated parts into lung.
R-213	5 yrs. Female White	Small pieces of chewed up spices	Left lower bronchus 4 weeks	None	5 mm.	25 min.	Extraction and cure	
R-303	23 yrs. Female White	Stem of match	Right lower bronchus 15 days	None	7 mm.	12 min.	Extraction and cure	
M-360	55 yrs. Male White	Blade of grass	Beginning esophagus 3 hours	None	Short esoph- ago- scope	2 min.	Extraction and cure	This foreign body gave as much discomfort to the patient as any I have ever seen. I never understood why it did not go down.

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
V-313	9 mos. Male White	Several ends of grass with seed	Lower right bronchus 8 hours	None	4 mm.	6 min.	Extraction and cure	
	3 yrs. Female White	Button	Beginning esophagus I hour	None	Short esoph- ago- scope	1 min.	Extraction and cure	
T- 170	3 yrs. Male White	Peanut	Right bronchus 2 weeks	None	5 mm. bron- cho- scope	7 min.	Extraction and cure	
T-390 T-329	19 mos, Female White	Peanut	Right bronchus 2 weeks	None	5 mm. bron- cho- scope	5 min.	Extraction and cure	
W-319	13 mos. Female White	Husk of peanut	Right bronchus 36 hours	None	4 mm. bron- cho- scope	8 min.	Extraction and cure	Child came in with a severe trached bronchitis and much laryngeal edema. How ever, a tracheotomy did not have to be per formed.
	5 yrs. Female White	Small pieces of peanut	Right bronchus 9 days	None	5 mm. bron- cho- scope	40 min.		Bronchopneumonia, laryngeal edema, lur abscess. Child still has chronic bronchitis.
T-2	21 mos. Male White	Peanut	Right lower bronchus 36 hours	Ether	5 mm.		Extraction trache- otomy	Death 3 days later. Probably embolus.
K-306	13 mos. Female White		Right and left bronchi 30 hours	None	5 mm. bron- cho- scope	5 min.	Extraction and cure	
W-107	Ho yrs. Male White	Pecan shell	Right bronehus 36 hours	None	5 mm. bron- cho- scope	7 min.	Extraction and cure	
V-31		1						

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Record No.	Age	Foreign Body	Location	Ancs- thetic	Tube	Time	Result	('omment
W-321	22 mos. Male White	Pecan	Left bronchus 40 hrs.	None	No. 4 bron- cho- scope	6 min.	Extraction and cure	
T-390	3 yrs. Female White	Pennut	Right bronchus 2 weeks	None	5 mm.	15 min.	Died	Trachcotomy, died 12 hours later.
S-379	15 mos. Male White	Pecan	Left bronchus 6 days	None	4 mm.	35 min.	Extraction and cure	Much congestion and high temperature. Fever reduced in three days to normal.
R-495	2 yrs. Female White	Penny	Cardiac end of esophagus 6 weeks	None	5 mm.		Penny passed in- to stomach probably from gagging	Penny remained in stomach two and one- half days before passing into small intes- tines.
ONE CENT LINITOSTATE OFFICE AND ADDRESS OF THE PARTY OF T	10 mos. P∈male White	Penny	E-ophagus 6 hours	None	Short esoph- agus	2 min.	Extraction and cure	
5-91	31 ₂ yrs. Male White	Penny	Cardiac end of esophagus 1 hour	None	7 mm.	4 min.	Extraction and cure	
S-484	21 ₂ yrs. Female White	Nickel	Midway esophagus 3 days	None	5 mm.	25 seconds	Extraction and cure	Mother gave a history of child swallowing a quarter.
S-373	I yr. Male White	Nickel	Midway esophagus 8 hours	None	5 mm.	1 min.	Extraction and cure	Mother gave a history of child swallowing a dime.

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
5-20	4 yrs. Female White	Nickel	Lower esophagus 6 weeks	None	5 mm.	12 min.	Extraction and cure	Coin had made a false pocket, which was overridden on first two inspections.
G-6769	2½ yrs. Female White	Nickel	Beginning esophagus 3 days	None	Laryn- goscope	50 seconds	Extraction and cure	
R-99	6 yrs. Male White	Can opener	Esophagus 1 hour	None	Laryn- goscope	1 min.	Extraction and cure	
V-463	43 yrs. Male White	Chewing gum	Right bronchus 72 hours	Local morphine gr., 14	7 mm.	10 min.	Extraction and cure	It is a wonder that we do not have more foreign bodies of this sort. Was chewing gum and some one slapped him on the back and he aspirated same.
T-30	6 yrs. Male White	Piece of kiddie kar	Esophagus 4 hours	None	6 mm.	I min.	Extraction and cure	X-ray picture looked like a half of a safety razor blade.
R-144	6 yrs. Male White	Piece of apple	Midway esophagus at point of old lye stricture 3 hours	None	7 mm.	6 min.	Extraction and cure	This case had not been dilated for about a year. He evidently got hold of too large a piece of apple.
5-93	3 yrs. Male Colored	Grain of corn	Lower right bronchus 1 week	None	5 mm.	22 min.	Extraction and cure	
V-485	3 yrs. Female Colored	Grain of corn	Left bronchus 24 hours	None	5 mm.	3 min.	Extraction and cure	

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
V-366	11 yrs. Female White	Grain of corn	Right bronchus 5 days	None	5 mm.	12 min.	Extraction and cure	This was a rather large piece of corn and was wedged tightly in the bronchus. After two unsuccessful attempts, we were able to remove same on third attempt.
V-368	2 yrs. Male White	Grain of corn	Right bronchus 8 hours	None	5 mm.	3 min.	Extraction and cure	
W-122	4 yrs. Male White	Grain of corn	Right hronchus 11 days	None	5 mm.	1 min.	Extraction and cure	
S-432	2½ yrs. Male White	Several pieces of corn	Right and left bronchi 4 days	None	5 mm.	28 min.		Lungs much congested. Went away next morning all right.
T-200	21 yrs. Female White	Many particles of canned corn and food	Right and left bronchi	Local	7 mm.	12 min.	Extraction and cure	This patient was being given an anesthetic in the final stages of labor, when she vomited and aspirated many particles of canned corn and some other food. Bronchoscopy was performed several hours after labor, with no ill effects to the mother or child.
K-186	13 yrs. Female White	Peanut	Esophagus at site of old lye stricture 1 week	None	7 mm. esoph- age- scepe and retro- grade bougie	2 min.	Extraction and cure	I had been dilating this case retrogradely and had dismissed her over to the surgeons for closure of gastrostomy wound when the day before she was to be c'osed she ate some peanuts. I made an attempt to remove the peanut from above but I could not move same. Working through the gastrostomy wound I was able to push the peanut into the mouth with a bougie and recover same.
F-156	12 yrs. Female White	Straight	Midway esophagus 3 hours	None	7 mm.	2 min.	Extraction and cure	
G-3172	7 yrs. Male White	Straight pin	Esophagus	None	5 mm.	1 min. 30 sec.	Extract or and cure	
T-338	3 yrs. Male White	Straight pin bent at right angles at point head down	Bent point in trachea rest of pin in esophagus 24 hours	Local	5 mm.	3 min.	Extraction and cure	Pulled point out of trachea and removed point up.

Record No.	Age	Foreign Body	Location	Anes-	Tube	Time	Result	Comment
R-380	3 yrs. Female White	Straight pin esophagus	Cardiac end of esophagus later in stomach	None	7 mm. esoph- ago- scope	2 min.	Not recovered	As I reached the cardiac end of the esophagus the pin could be distinctly seen, but as I introduced the forceps it passed into the stomach. Two days later it was recovered in the stool.
5-121	4 mos. F∈male White	Safety pin point up in Tissue	Beginning teophagus 2 hours	None	5 mm.	3 min.	Extraction and cure	Pin had to he turned around before extraction could be done.
V-97	8 mos, Female White	Open safety pin point up	Beginning esophagus 7 hours	- None	5 mm.	2 min.	Extraction and cure	Pin turned and removed with point downward.
W-188	1 yr. Male White	Open safety pin	Midway esophagus 8 hours	None	5 mm.	30 seconds	Extraction and cure	
T-292	8 yrs. Female White	safety pin	Midway esophagus 3 hours	None	5 mm.	3 min.	Extraction and cure	
	Female	safety	Left bronchus 4 hours		7 mm. bron- cho- scope	10 min.	I I I I S s t	This case was X-rayed in another city and the tin as a foreign body in the esophagus. esophagoscoped the patient, but could find no pin. Another X-ray was made and the poin located in the left bronchus, point up. The point was fortunately near the carina to that the point was first brought up. The urned and pushed down in the right pronchus and the pin removed by grasping the spring end.

Record No.	Age	Foreign Body	Location	Anes- thetic	Tube	Time	Result	Comment
S-201	5 yrs. Female Colored	Safety pin and open point up in vocal cords	Trachea and vocal cords 4 days	None	5 mm.	3 min.	Extraction and cure	Had to use safety pin closer—turn point around until it projected through opening between cords, then grap point and get into bronchoscope and remove.
V-252	10 mos. Female White	Open safety pin	Midway esophagus point perforating esophagus 24 horus	None	5 mm.	31 ₂ min. 2 min.	Extraction and cure	On first attempt we tried to disladge point and close pin, but we could not do so. On second attempt we pushed pin downward in esophagus and disladged point and then pulled point into esophagoscope and removed same.
V-289	2½ yrs. Female White	Open safety pin	Esophagus 1 hour	None	Short 7 mm. esoph- ago- scope	3 min.	Extraction and cure	Pin point down grasped by spring end.
W-291 (C)	11 mos. Female Colored	Open safety pin point up	Midway down esophagus 4 hours	None	5 mm. esoph- ago- scope	2 min.	Extraction and cure	Pin grasped by point and point pulled up into esophagoscope and pin removed.
W-232	3 yrs. Female White	Needle	Esophagus 6 hours	None	5 mm.	30 seconds		In removing the needle it broke in half, leaving the pointed end in the soft tissues; however, I was able on returning to see a small end protruding from the soft tissues and remove same.
R-242	19 yrs. Female White	Ring	Esophagus 30 minutes	None	7 mm.	6 min.		As I grasped the ring it slipped and went into the stomach and passed two days later.

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PRE-CONVENTION MEETING

The informal pre-convention meeting of the Florida Medical Association was held at 7:00 p. m. in the San Juan Hotel in Orlando February 27th, at the call of the President, Dr. G. H. Edwards. There were present the officers of the association, committeemen and councilors.

Before the regular meeting various committee meetings were held. The Scientific Program Committee selected 18 papers from 50 applications which were presented for consideration. These will be presented at the Sarasota session in May. Many other papers were deserving of presentation, but the time allotted for the scientific

session would permit no more. These papers, when read before some county society, might well be offered to the Journal for publication, as they contained a great deal of illuminating information.

The Executive Committee met, discussed many matters and formulated a report which will be presented before the State Convention. Later it met with the Committee on Public Relations and discussed the progress of the educational campaign by that committee through newspapers and radios.

Very few Councilors were present but a meeting was held and Dr. Samuel Puleston of Sanford was elected Chairman and Dr. Meredith Mallory of Orlando, secretary.

Dr. R. H. McGinnis of Jacksonville was named as chairman of the Committee on Necrology, which is formulating resolutions for presentation at the state session regarding our departed members.

Dr. Jack Halton, President of the Sarasota County Medical Society told of the activities of that Society in making plans for our entertainment the 3rd and 4th of May.

Dr. T. H. Bates, president of the Florida Railway Surgeons' Association had a meeting of his executive and scientific committees and made plans for their meeting in Sarasota on the day preceding the State Association meeting.

After the dinner, the chairmen of the various committees made brief reports as to their plans for the State Convention and the councilors present read their reports. A number who were unable to be present had mailed in their reports and they were read by the secretary of the Association and submitted for publication.

The Committee on Revision of Constitution and By-Laws read the suggested changes, most of which met with the approval of the members present. One section changing the hour of election of the officers from noon of the second day to the afternoon of the third produced a great deal of discussion, participated in by nearly every one present. The discussion involved not only the day of the election of the officers, but also the arrangement of the various sessions; the hours at which the sessions should convene; the question as to the advisability of introductory address and response, etc.

Following this general meeting the officers of the Association, with the President of the Sarasota Club, and the Chairman of the Program Committee, met and arranged a schedule for the

Sarasota Convention which eliminates the introductory address. Two papers will be presented the morning of the first day, following the presidential address and the oration which will be delivered by Dr. Bierring of Des Moines, Iowa; five in the afternoon of the first day; three at the evening session on the first day; five on the morning of the second day and three in the afternoon of the second day. This will allow the majority of the men to hear the presentation of all the papers and be able to get to their homes that night.

The following members of the Association were present:

Edwards, G. II., President	Orlando
Richardson, Shaler, Secretary	Jacksonville
Adamson, Wm. P	
Allen, Bundy	
Bates, T. H	
Christ, C. D	
Dozier, H. C.	
Driskell, S. E	
Feaster, O. O	
Flipse, M. J.	
Greene, Ralph N	
Halton, Jack	
Holden, Gerry R	
Irwin, J. M	
Jobson, A. M. C.	
McEwan, John S	
Mallory, Meredith	
Puleston, Samuel	
Shackelford, C. W	
Smith, H. Mason	
Spiers, Wm. H	
Waas, F. J.	
Warren, E. W.	
Wells, J. Ralston	
Wood, A. J.	
Stewart Thompson, Business Manage	
1 1, 1 1, 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3

REPORTS OF DISTRICT COUNCILORS FIRST DISTRICT—J. M. HOFFMAN, M.D. . . Pensacola Okaloosa, Walton, Santa Rosa, Escambia.

I beg to submit my annual report as Councilor of the Florida Medical Association, District One. The district comprises Escambia, Santa Rosa, Okaloosa and Walton Counties.

Okaloosa and Walton County members are united in the Bi-County Society, which has held regular monthly meetings, alternating between DeFuniak Springs and Crestview as meeting places. The membership of this Society is small, but the meetings are well attended. Case reports usually constitute the program of the meetings with few formal papers. All eligible doctors are members of this Society, in these counties.

The Escambia County Medical Society is composed of members from Santa Rosa and Escambia counties. Regular monthly meetings are held throughout the year except June, July and August. One formal paper is presented at each meeting.

One general meeting and buffet supper was held in November, to which the Army and Navy Medical personnel, and County Society members from contiguous Alabama Counties were invited. The program was given by members of the Society. Medical problems of common interest were discussed.

This Society, through its committee, was instrumental in the formation of a County Health Unit, cooperating with the State Board of Health, and incorporating the services in this Unit, of a full-time City-County physician, who will cooperate with the Director of the Health Unit. The Society is about to see its efforts rewarded, as the Unit is scheduled to begin operation on March 1, 1932.

Several physicians now reside in Escambia County, who are duly licensed to practice medicine in Florida, but are not members of the County Society. None of these doctors are considered eligible by the Board of Censors.

The membership in this District of the State are evincing a keen interest in medical matters as evidenced by their attendance at all major medical conventions of the country. They seem vitally interested in their State Association affairs, and are keeping in touch with the problems that are Leing worked out by their parent organization.

SECOND DISTRICT-O. G. KENDRICK, M.D.,

Tallahassee Liberty, Gadsden, Jefferson, Wakulla, Leon, Franklin.

The Second District of Florida Medical Association comprises the counties of Jefferson, Leon, Wakulla, Gadsden, Liberty, and Franklin. There is only one medical organization in the district, the Second District Medical Society, which meets quarterly and rotates from Monticello, Tallahassee, Quincy, and Chattahoochee.

Meetings are held in January, April, July, and October.

Meetings are well attended by the members except those from Liberty and Franklin who are handicapped because of distance and ferry schedules. Many of the physicians from southern portions of Georgia attend our meetings and add thereto by their discussions on subjects presented.

Officers for the year 1932 were elected at the October meeting which was held at Florida State Hospital, Chattahoochee. The following officers were elected:

President—W. W. Massey, Quincy. Vice-President—B. A. Wilkinson, Tallahassee. Sec'y-Treasurer—O. G. Kendrick, Tallahassee. THIRD DISTRICT—T. H. BATES, M.D. . Live Oak Hamilton, Dixie, Taylor, Madison, Columbia, Suwannee, Lafavette.

As Councilor of the Third District I beg to submit the following report:

The district consisting of the counties of Columbia, Dixie, Hamilton, Lafayette, Medison, Suwannee and Taylor, is served by three county medical societies, namely: Columbia, Madison and Taylor County Medical Societies. The district is also served by a local society known as the Suwannee River Medical Society, the membership of which is made up of physicians residing in the counties that border on the Suwannee River. It is felt that this local organization because of its low rate of dues has to a large degree taken the place of the county unit and the State Association in the minds of a great many of the physicians. The former members of the Suwannee County Society very frankly state that the matter of dues is entirely responsible for the Suwannee Society having been discontinued, and they state that they will not make any effort whatsoever to reorganize their county unit until such time as dues in the Florida Medical Association are reduced very materially. Madison County with only nine physicians has only five who are eligible for membership in the State Association. Lafavette county is served by only one physician. Dixie county is served by six physicians, one less than they had in 1931. A letter from one of these indicates that several of them would like to have membership in the State Association, but that they have not been shown much cordiality by the county societies nearest to which they are located. The situation in Columbia county shows an active membership consisting of practically all of the eligible physicians in Lake City, and one man from the staff of the U.S. Veterans' hospital. A majority of the staff of the veterans' hospital are not strictly eligible to membership in the county society because of the lack of Florida registration. The spirit of cooperation among the physicians in the district is very good, and except for a few instances there is little friction.

There is one negro physician in the district. He is clean-cut in his practice, maintains membership in the negroes' state medical organization and has the confidence and respect of the white physicians of his community.

SIXTH DISTRICT-J. A. STRICKLAND, M.D.,

St. Petersburg

Pinellas. I beg to submit the following report of the

Pinellas County Medical Society, which is under the leadership of President O. O. Feaster:

The Society is composed of 80 members, 49 having paid their dues up to date. The following new members have been added this year: Dr. A. P. Roope, Dr. T. H. Green, Dr. W. P. Farber, Dr. J. A. B. Quicksall.

Our programs this year have been very interesting and well attended, due to the excellent work of our very efficient program committee.

One meeting of special interest was the meeting of February 25, 1932. Two papers as follows:

"Polionyelitis and Its After Treatment by Means of Exercise and Warm Water as Carried Out at Warm Springs, Ga." By Leroy W. Hubbard, M.D., director of Extension of the Georgia Warm Springs Foundation, Inc.

Illustrated moving pictures of some of the more common tropical diseases found in Africa, as observed during a residency of thirty years in this country. By H. L. Weber, M.D., director of Medical Missions, West Africa.

Officers for the current year are:

President—O. O. Feaster.

First Vice-President—L. M. Gable.

Second Vice-President-W. G. Post, Ir.

Secretary—A. L. Mills.

Treasurer—G. E. Miller.

TENTH DISTRICT-WALTER A. WEED, M.D., Lakeland Polk.

The Polk County Medical Society has an active membership of fifty-five, with only two members delinquent in the payment of dues for the year 1931. There are nine physicians in the county not affiliated with the local society. There are no illegal practitioners in the county so far as I know.

The Society meets on the second Wednesday in February, April, June, August, October and December, and during the year has met twice in Lakeland, three times in Bartow, and once in Lake Wales. The average attendance is from twentyfive to thirty. Three new members have been accepted during the year, and there has been only one death among the membership.

At the Lake Wales meeting in December, the following named officers were elected for the ensuing year, viz.:

President—J. L. Hargrove, Bartow.

Vice-President—R. L. Hughes, Bartow.

Sec'y-Treasurer—Herman Watson, Lakeland.

TWELFTH DISTRICT-W. H. GRACE, M.D., Ft. Myers Glades, Charlotte, Hendry, Lee, Collier.

As Councilor of the Twelfth District, which comprises the counties of Collier, Hendry, Glades, Charlotte, and Lee, I wish to submit the following report:

Lee county is the only one of the five counties in the district which has a medical society, due to the fact that there are not enough physicians in any of the other counties to form a society. 1 have written to all of the physicians in the counties comprising the district, inviting them to join the Lee county society, but the distance is too great for most of them to be able to attend.

It was voted at the last meeting to hold quarterly meetings instead of monthly ones. Our membership numbers the same as last year. We gained a member but lost one, Dr. Alvin Stebbins, who recently opened up an office in Howey-in-the-Hills.

THIRTEENTH DISTRICT-J. W. ALSOBROOK, M.D.,

Hillsborough, Hernando, Pasco.

Hillsborough County Medical Society has missed no regular meeting during the past year. The attendance has been above the average.

Membership, 1931, 98, with 86 paid and 12 delinquents. Thus far in 1932 we have few paid memberships but we hope to be 100 per cent paid before April 1st.

In addition to the regular monthly programs furnished by the members we have had papers or lectures by three distinguished guests: Mrs. Post of Massachusetts on Birth Control; Dr. Ralph Greene of Jacksonville on Relation of Neurology to Medicine; Dr. F. C. Metzger of Sarasota on Allergy.

The new officers are: President-L. F. Carlton. Vice-President—E. S. Gilmer. Sec'y-Treasurer—James T. Cowart.

FIFTEENTH DISTRICT-LEIGH F. ROBINSON, Ft. Lauderdale

Palm Beach, Broward.

I herewith submit my report as Councilor of the Fifteenth District, composed of Palm Beach and Broward Counties.

The Palm Beach Society has enjoyed what most of its members believe to be its best year. Their meetings have been characteriezd by better harmony, keener interest, and an absence of friction. Twenty to thirty-five is the usual attendance out of the membership of forty-three. The meetings are held on the fourth Monday of each month at the Good Samaritan Hospital and in conjunction with the monthly staff meetings, since the staff is composed of the members of the County Society.

The same group of men composing the two organizations has been able, by holding the meetings on the same date, to stimulate greater interest in both the county and staff work. The program committee invariably provides an interesting program and the members therefore make every effort to be in attendance.

Broward county also had a very good year. Its membership is nineteen in number and the attendance at the meetings average between ten and fifteen. Interesting programs were held at several of the meetings, particularly during the winter months when a number of prominent medical men were in the city. Through the efforts of the county society the old Memorial Hospital has been reopened, and with the assistance of the county and city commissioners has been modernized and now provides for this county adequate hospital facilities. The staff is composed of members of the Broward County Society.

I wish to express my appreciation for the cooperation and assistance of those members and officers of the societies of my district who have assisted me in my work.

SIXTEENTH DISTRICT—W. L. ASHTON, M.D., Umatilla Sumter, Lake.

The Sixteenth District comprising the above two counties is well organized. Sumter County Society consists of all of the eligible men, four in number, who meet regularly and take an active interest in joint meetings periodically with Lake county and Central Florida societies.

Lake County Society has augmented her membership roster by the addition of three members, bringing same to eighteen, the maximum enrollment in the history of the society. One member was lost by resignation by reason of failing health and alleged excessive dues. One other eligible practitioner, although invited has not effected membership.

Attendance at the regular meetings range well over sixty per cent and programs are interspersed with scientific papers by its own members, an occasional motion picture film of medical interest, and papers by outside physicians. By reason of the goodly reserve in the treasury and the present depression, the society elected to reduce the

county dues from \$5.00 to \$2.00 which should aid in maintaining the society in the 100% paid-up column.

SEVENTEENTH DISTRICT— Meredith Mallory, M.D. Orlando Osceola, Orange.

The Seventeenth District comprising the counties of Osceola and Orange has one organized medical society, the Orange County Medical Society, which had the pleasure of being host to the Florida Medical Association last May. There have been regular monthly meetings with papers at every meeting except at the annual banquet. The attendance has been very good, being a little over seventy per cent. Four men have moved to other localities and there have been two losses through death, while only one new member has been added to the membership. Through the activities of the members from Orlando it was possible to convince the Orlando City Commission that Christian Science practitioners should be subject to an occupational tax the same as other people practicing a healing art.

The officers for this year elected at the December meeting are:

President—G. S. Osincup, Orlando. Vice-President—Hewitt Johnston, Orlando. Secretary—I. M. Orr, Orlando. Treasurer—C. J. Collins, Orlando.

I as your Councilor beg leave to report that the Manatee and Sarasota medical societies have met regularly each month, each society furnishing the program every other month. The plan has worked well and the programs have been interesting and discussed freely. Everything has been in harmony. We have had one new member added to the Manatee County Society, Dr. A. J. Floyd of Palmetto.

MEDICAL CARE AND TREATMENT OF MERCHANT SEAMEN AND OTHER BENEFICIARIES OF THE PUBLIC HEALTH SERVICE

In 157 ports of the United States and its possessions hospital care, out-patient treatment, and other medical services were furnished by the United States Public Health Service to American merchant seamen and other legal beneficiaries during the fiscal year 1931. Although 90 per cent of the hospital treatment is furnished in the

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marine hospitals, the Public Health Service maintains contracts with 196 public and private hospitals in the smaller and remote ports. Merchant seamen continued to be the most important class of beneficiaries, receiving 3.3 per cent more hospital treatment and 14 per cent more out-patient relief than in the preceding year. In addition to the treatment provided at the marine hospitals and other regular relief stations for the Coast Guard, which now has a personnel of more than 13,000 men, 22 medical and dental officers were detailed for duty on vessels and elsewhere and 108 part-time local physicians served isolated Coast Guard units. The usual assistance was given to the Civil Service Commission, the Steam boat Inspection Service, Employees' Compensation Commission, Veterans' Administration and other government establishments.

The medical services furnished for the Employees' Compensation Commission would, it is estimated, have cost the compensation fund more than \$1,000,000 if obtained from private sources. A daily average of 842 patients of the Veterans' Administration were treated in marine hospitals in ports where the use of these institutions has made the construction of special hospitals unnecessary. Cooperation with the Veterans' Administration has been close and cordial.

For all classes of beneficiaries an aggregate of 1,666,215 hospital patient days and 910,466 outpatient treatments were furnished, and 94,487 physical examinations made for purposes other than medical treatment. The number of leper patients at the National Leper Home operated by the United States Public Health Service at Carville, La., increased from 308 to 337 during the year.

Satisfactory progress has been made with the building program. Construction of the new marine hospitals at Galveston, San Francisco and New Orleans has nearly been completed and work has commenced on the Seattle institution. The contract has been let for the addition at Key West. Architects are engaged in the preparation of plans for the new marine hospital buildings at Stapleton, New York, Baltimore, Norfolk, Louisville, Chicago, Evansville, Detroit, Memphis and Mobile. The building program not yet provided for includes additional or improved hospital facilities for the National Leper Home and the marine hospitals in Boston, Buffalo, Pittsburgh, St. Louis, Portland, Maine, and Fort Stanton, New Mexico.

SOUTHEASTERN SURGICAL CONGRESS

The Southeastern Surgical Congress held its third annual meeting at Birmingham, Alabama, March 7, 8 and 9. This was an outstanding meeting, as have been its two previous meetings. Some of the leading surgical men of the country contributed to this program as did a goodly number of our Southern men. Dr. Ralph N. Greene of Jacksonville represented Florida on this program. His address, "Neurology as Related to Surgery," was well received.

The following Fellows of the Congress residing in Florida attended: Drs. A. M. Ames, Pensacola; T. H. Bates, Lake City; Julius C. Davis, Quincy; L. C. Ingram, Orlando; G. C. Tillman, Gainesville; J. S. Turberville, Century; C. C. Webb, Pensacola, and J. Ralston Wells, Daytona Beach.

The following physicians from Florida registered as visitors: Drs. R. O. Cheny, Lake City; R. F. Godard, Quincy; Ralph N. Greene, Jacksonville; D. A. McKinnon, Marianna; T. H. Snow, Gainesville; J. A. Thurston, Lake City.

THE NEXT MEETING
OF THE
FLORIDA MEDICAL
ASSOCIATION
WILL BE HELD AT
SARASOTA
MAY 3-4, 1932

TECHNICAL EXHIBITS

The management of the Technical Exhibits at the Sarasota convention will again be in the hands of the business office of the state Association. For three consecutive years the exhibits have been handled by the Association and this arrangement has apparently worked out to the best interests of all concerned. Both exhibitors and the different entertaining societies have expressed themselves well pleased.

Exhibit spaces will be available in the lobby and also on the mezzanine floor of the Sarasota Terrace Hotel. Our members are urged to visit the booth of every exhibitor. The doctor who keeps himself abreast with the times will find the exhibits both interesting and instructive.

Florida Medical Association, Inc.

JACKSONVILLE. FLORIDA P. O. BOX 81

SHALER RICHARDSON, M. D. SECRETARY-TREASURER AND EDITOR OF THE JOURNAL

STEWART G. THOMPSON. D. P. H. BUSINESS MANAGER AND DIRECTOR OF EXHIBITS

Regulations Regarding Exhibits

Arrangement of Exhibits. The management will provide skeleton booths as indicated in diagrams, also signs of uniform style. No interference with the light or space of other exhibitors will be al-

Exhibitor is responsible for damage to property. No signs or other articles shall be posted, nailed, or otherwise attached to any of the pillars, walls, doors, etc., in such manner as to deface or destroy the same. No attachments can be made to the floors by nails, screws, or any other devices that would in any way damage or mar them. All space leased subject to these restrictions.

Restrictions.—Exhibits should be confined, as far as practicable, to special articles, articles that are new, unique, or particularly attractive and scientific in character.

No proprietary drugs, chemicals, or therapeutic agents that do not comply with the rules of the Council on Pharmacy and Chemistry of the American Medical Association or which have not been accepted by the Council for inclusion in "New and Non-official Remedies". can be exhibited, distributed, or in any way advertised in the hotel. (For copy of official rules of the Council on Pharmacy and Chemistry, write A. M. A.)

No medical journal or publication can be exhibited that contains advertisements of drugs, chemicals, or any therapeutic agents which do not conform to the rules of the Council on Pharmacy and Chemistry of the American Medical Association.

Irregular Canvassing and Distribution of Advertising Matter.—Solicitation of business or conferences in the interests of business except by exhibiting firms, is prohibited. Canvassing by exhibitors outside of their booths is also forbidden. Circulars or advertising matter of any description cannot be distributed, excepting from the Exhibitor's booth.

Exhibits of Electrical and Radiographic Appa-Exhibits of Electrical and Radiographic Apparatus.—Machines and apparatus operated by electricity must be shown as "still" exhibits. Practical demonstrations of X-ray apparatus and accessories or of any noisy apparatus of any kind will not be permitted. No objection will be made to the utilization of electricity for illuminating purposes or for operating smaller diagnostic instruments and electro-therapeutic apparatus which are noiseless.

Subletting of Space.—No subletting of space will be permitted. Each firm represented in the Technical Exhibit must sign the regular form "Application for Space in the Technical Exhibit." Any person or firm subletting space as well as the one purchasing space, will be subject to eviction. No refund will be made for space reserved.

Uncontrollable Eventualities. The Florida Medical Association, Inc., will take all reasonable pre-cautions against damage or loss by fire, water, storm, theft, strikes and other emergencies of that character, but does not guarantee or insure the Exhibitor against loss by reason thereof.

Cooperation of Exhibitor Requested .- The foregoing regulations with reference to exhibits have been formulated for the best interests of exhibitors and the hearty cooperation of our patrons is requested. All points not covered are subject to settlement by the management.

Space is leased with the understanding that the Exhibitor will hold the Florida Medical Association, Inc., harmless from any or all liability which results from any cause whatsoever within the control of said Exhibitor.

Application for SPACE in the

Technical Exhibit

at the Fifty-ninth Annual Meeting

Florida Medical Association, Inc. HOTEL SARASOTA TERRACE SARASOTA

May 2, 3 and 4, 1932

FLORIDA MEDICAL ASSOCIATION, Inc. Box 81

Jacksonville, Florida

You are hereby authorized to reserve for our use space in the Technical Exhibit at the Hotel Sarasota Terrace for the Fifty-Ninth Annual Meeting of the Florida Medical Association, Inc., May, 1932.

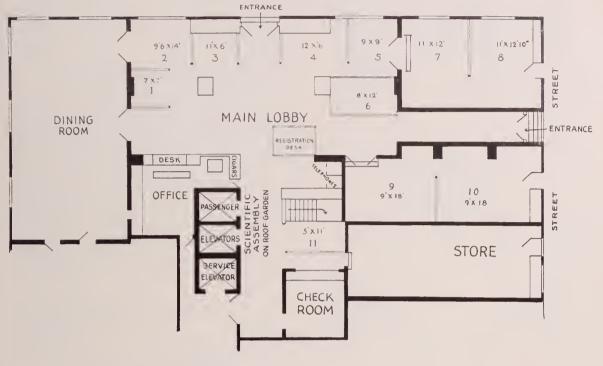
Our First	Choice is Space	No;	at	\$
Our Second	Choice is Space	No;	at	\$
Our Third	Choice is Space	No;	at	\$
Our Fourth	Choice is Space	No;	at	\$
Our Fifth	Choice is Space	No ·	at	S

(Make five selections. Space will be assigned in the order in which contracts are received.)

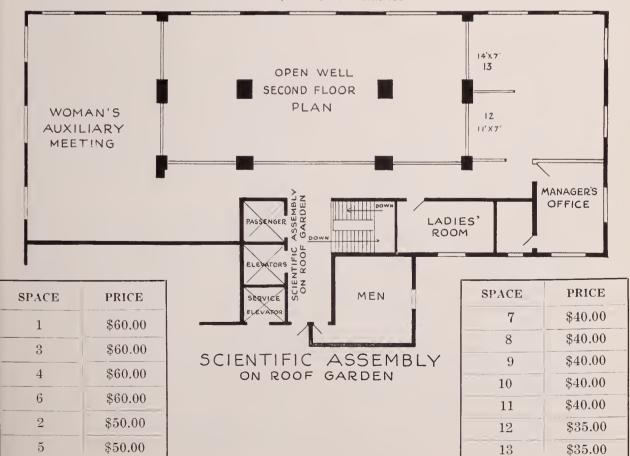
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(Print here two-line copy for your identification Sign.)	

(Sign Painter's Copy)

SCHEDULE OF EXHIBIT SPACES AND PRICES SARASOTA, 1932



MEZZANINE, SARASOTA TERRACE



STATE NEWS ITEMS

Dr. Robert H. McGinnis of Jacksonville was recently appointed chairman of the Committee on Necrology and will make a formal report at the annual meeting in Sarasota.

* * *

Dr. L. M. Anderson of Lake City, who claims thirty-six consecutive years' membership in the Florida Medical Association, was recently a visitor in Jacksonville.

* * *

Dr. L. S. Laffitte, formerly of Gulf Hammock, has received an appointment to residency for one year at Bellevue Hospital, New York City.

* * *

Dr. J. P. Daniels of Pensacola was recently appointed county physician of Escambia County to succeed Dr. V. R. Nobles.

* * *

The fifth radio broadcast of the State Association over WRUF, was given on February 10th by Dr. Henry C. Dozier of Ocala. His subject was "The Medical Profession—Its Economic Contributions to the State of Florida." The music which interspersed the broadcast was furnished by Dr. Dozier.

Dr. E. T. Craney of Orlando died Monday, February 22nd, after a brief illness.

* * *

The Central Florida Medical Society held its semi-annual meeting at the Hotel Thomas, Gainesville, Thursday, February 25th. Many doctors from other parts of the state were in attendance and their ladies were invited guests. The following program proved of great interest:

Address of Welcome—J. H. Colson, Gainesville, President of Alachua County Medical Society.Response: H. S. Cherry, Center Hill, President Central Florida Medical Society.

Childhood Type of Tuberculosis—Louie Limbaugh, Jacksonville.

Case Reports—Thomas M. Palmer, Jacksonville. Exhibition of X-ray Plates—W. M. Shaw, Jacksonville.

The newly named officers are:

President—W. C. Thomas, Gainesville. Vice-President—J. N. Moore, Ocala. Vice-President—R. E. Summitt, Eustis. Vice-President—Geo. C. Tillman, Gainesville. Vice-President—A. P. Albritton, Wildwood. Secretary-Treasurer—R. H. Williams, Eustis.

At a meeting of the Councilors, held in Orlando February 27th, Dr. Samuel Puleston of Sanford was elected chairman and Dr. Meredith Mallory, Orlando, secretary, in accordance with Chapter VII of the Association's By-Laws. Dr. Puleston, the chairman, will present a report at the annual meeting in Sarasota.

GEORGE W. WOOD

Dr. Wood was born in Maryland, July 25, 1863. For years he practiced medicine in Washington, D. C. In 1925 he came to Rockledge with his family where he carried on his profession until the time of his death, November 9, 1931. The following resolutions were recently adopted by the Brevard County Medical Society with reference to the passing of Dr. Wood:

"Whereas, it has pleased Almighty God in His infinite wisdom to take from among us our beloved friend and brother physician, Dr. George W. Wood, and

"Whereas, Dr. George W. Wood, by his genial personality and wholehearted friendship has endeared himself to each and every member of the medical profession wherever he has been; and through his high ideals and professional ability has materially contributed to the upbuilding of the practice and art of medicine in Brevard county; and by his valued counsel and cooperation has been a sincere friend to all of us, and

"Whereas, by his untiring devotion to the practice of medicine and his continued sacrifices in the interest of charity he has endeared himself to the entire community, and

"Whereas, We, the members of the Brevard County Medical Society, feel deeply the loss of our esteemed friend and former vice-president of this society,

"Therefore, Be it Resolved, That the Brevard County Medical Society express its sorrow in the passing of Doctor Wood; that a copy of this resolution be forwarded to the wife, his daughter and other members of his family; that a copy be entered on the minutes of this Society in order that the doctors of Brevard county may know forever the high esteem in which we held him and that the same be published in the Journal of the Florida Medical Association and the local press.

"Brevard County Medical Society,
"E. W. Potthoff, President;
"I. K. Hicks, Secretary."

ROBERT LEE BRYANS

Dr. Robert Lee Bryans died at his office in Pensacola very suddenly, on November 18th. He was seventy-four years old at the time of his death.

Dr. Bryans graduated from the Atlanta Medical College in 1892. He came to Pensacola in 1900 to practice his profession. Dr. Bryans was a member of the Escambia County Medical Society, the Gadsden Street Methodist Church, Pensacola Lodge No. 42, F. and A. M., and Knights of Pythias. He was formerly assistant chief surgeon of the Plant railroad system.

Dr. Bryans is survived by his widow, Mrs. Amie Bryans, one son, Dr. Herbert Bryans, and one daughter, Mary Roberta Bryans of Pensacola.

Dr. Louis H. Van Engelken, for many years a resident of Ocala, died on January 6th.

Dr. Walter E. Edwards of Polk City, a member of the Polk County Medical Society, died January 9th.

COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

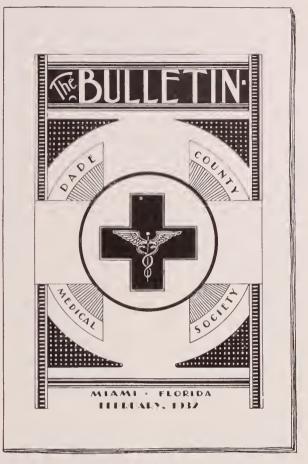
Broward County Medical Society met in their new location, the Legion room of Elks Hall, Feb. 24th. The meeting date of the society has been changed to the last Wednesday in each month. Drs. Burton Haseltine and John S. Ashby, both of Chicago, gave an illustrated talk on "The Origin and Treatment of Bronchial Asthma." Visitors were Dr. W. H. Watters of Boston, Dr. Bransford Lewis of St. Louis, Dr. Kenneth Phillips and Dr. Eugene Maxwell of Miami.

Dr. Anna Darrow of Ft. Lauderdale and Dr. Carleton Deederer of Miami had their paintings in water colors and oils hung at the Miami Woman's Club annual art exhibit, Feb. 18, 1932, and received favorable comment.

(Signed) Anna A. Darrow, M.D., Secretary.

DADE COUNTY MEDICAL SOCIETY

The cut shown above is a miniature reproduction of the front cover of a bulletin issued by the Dade County Medical Society. The February, 1932, issue was the first number of Volume I. Congratulations to the Dade County Medical Society. Dr. Homer L. Pearson is managing editor, Drs. Elmo D. French, Gerard Raap and Milton Coplan, associate editors, and Miss Hazel L. Schwartz,



secretary. The Bulletin is a very attractive twelve-page publication, size 6"x9". Its contents are well worth reading. They embrace editorials, case reports, minutes of society meetings, local news items and numerous advertisements.

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met in Arcadia Feb. 9th at 8 p. m. Dr. McKnight presided in the absence of President Dr. Chandler.

Those present were: Drs. Simmons, Kirkpatrick, Kayton, Pyatt, Bevis, McKnight, McSwain, Spears, Highsmith, and Martin. Visitors: Drs. Blake and Henderson of Tampa.

After a very delicious dinner with the auxiliary, Dr. W. C. Blake of Tampa read a paper on "Artificial Pneumothorax," discussed by Drs. Simmons, McKnight, McSwain, and Martin. This paper was followed by one on "Obstruction of the Urinary Tract," by Dr. Henderson, also of Tampa. This was discussed by Drs. Blake and Highsmith.

(Signed) L. W. MARTIN, Secretary.

JACKSON COUNTY MEDICAL SOCIETY

The Jackson County Medical Society met February 9th and elected the following officers for the current year:

President—Lewis Pierce, Marianna.
Sec'y-Treasurer—T. H. Hudgens, Sneads.

PACCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Pasco-Hernando-Citrus County Medical Society was held with Dr. J. T. Bradshaw, Thursday evening, February 11, 1932, at St. Leo, Florida.

A delicious roast duck dinner was served in the main dining room of the Abbey, followed by the scientific meeting in the office of Rev. Abbott Francis Sadler.

Dr. A. B. Cannon, the new President, called the meeting to order. Case reports were made by Drs. Cannon, Jackson, Furlow, Dame and Creekmore and discussed by all present.

Dr. James S. Estes of Tampa, Florida, read a very interesting paper on Urology and showed several pathological specimens and X-ray pictures.

Dr. George A. Dame of Inverness, Florida, invited the Society to meet with him, March 10. 1932.

Those present: Drs. Bradshaw, Cannon, Creekmore, Jackson, George Dame and Furlow. Invited guest, Dr. James S. Estes, of Tampa, Florida.

(Signed) G. R. Creekmore, Sec'y-Treasurer.

PINELLAS COUNTY MEDICAL SOCIETY

The meeting of the Pinellas County Medical Society was called to order by President O. O. Feaster, Thursday, February 25th, 1932, at 8:00 p. m. in the Assembly Room on the fifth floor of the Power & Light Building. Visitors included members of the St. Petersburg Dental Society, Mr. E. M. Berryman, Geo. R. West, M.D., Chattanooga, Tennessee; and C. B. Wood, M.D., Pittsburgh, Penn.

Dr. Prescott LeBreton exhibited two postoperative orthopedic cases, the first a case of achondroplasia or fetal rickets and the second a case of posterior dislocation of the hip, after open operation.

The first speaker of the evening was Dr. Leroy W. Hubbard, director of Warm Springs Founda-

tion, Inc., of Warm Springs, Ga. His subject was "Poliomyelitis, Its After Care and Treatment, by Suitable Exercises Under Water as Carried Out at Warm Springs, Ga."

A reel of moving pictures showing the Sanatorium, warm pools, methods of exercising different groups of muscles under water were shown. Doctor Hubbard's talk was extemporaneous and was well received.

The next speaker of the evening was Dr. H. I. Weber, director of Presbyterian Missions, West Africa. Doctor Weber is a graduate in medicine and dentistry and has spent thirty years in this tropical wilderness. Through his untiring efforts there have been built a two-hundred-bed hospital and two large leper colonies.

Doctor Weber exhibited three reels of moving pictures showing the hospital, leper colony, the native villages and several hunting expeditions, including a hippopotamus and elephant hunt.

The members of the Society thoroughly enjoyed Doctor Weber's talk and the unique moving pictures he exhibited.

(Signed) ALVIN L. MILLS, M.D., Secretary.

SEMINOLE COUNTY MEDICAL SOCIETY

THE SEMINOLE COUNTY MEDICAL SOCIETY HAS "GONE OVER THE TOP" FOR 1932. EVERY MEMBER OF THIS SOCIETY HAS PAID STATE DUES FOR THE CURRENT YEAR. DR. J. WM. MARTIN OF OVIEDO IS PRESIDENT OF THIS SOCIETY AND DR. JOHN T. DENTON OF SANFORD IS AGAIN SERVING AS SECRETARY-TREASURER.

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

At a recent meeting of the Walton-Okaloosa County Medical Society, the following officers were elected to serve for 1932:

President—R. B. Spiers, DeFuniak Springs. Vice-President—E. B. Webb, Crestview. Sec'y-Treasurer—A. G. Williams, Lakewood.

THE WALTON-OKALOOSA COUNTY MEDICAL SOCIETY HAS REPORTED 100% DUES FOR 1932. THIS SOCIETY HAS FOR MANY YEARS BEEN IN THE 100% PAID GROUP.

* *



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A modern neuropsychiatric hospital with special lab-oratory facilities for the study and treatment of early cases. Also a department for the treatment of drug and alcoholic addictions.

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What an intensely interesting page the Florida Woman's Auxiliary could have if the Publicity Chairman of every county Auxiliary would send the Editor some small item as often as possible! Of course we want these each month but would appreciate an item or an article at any time.

VOLUSIA COUNTY

The publicity chairman of this county Auxiliary and also our Past State President, Mrs. J. Ralston Wells, informs us that the Volusia County Auxiliary met on February the ninth, at the Ocean House in New Smyrna.

Mrs. Wells has very kindly contributed the following splendid article, entitled:

WHAT IT MEANS TO BE AN AUXILIARY MEMBER

The Woman's Auxiliary to the American Medical Association is a body of women, over 12,000 strong and growing all the time, whose aim is to be what its name implies—an auxiliary aid to the medical profession. Something more than a telephone girl, not quite a confidential secretary, rather a "contact man" whose job shall be to bring a closer understanding between the public and its loyal servant, and sometime slave, the medical profession.

When a woman allies herself with this organization, she has stepped out of her narrow circle into a broader field, where she joins hands with

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See Description, Journal A. M. A. Volume XLVII, Page 1488

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4

One of a series of messages in the Saturday Evening Post, the Literary Digest and other magazines, setting forth some of the accomplishments of Medical Science in the diagnosis, treatment, and prevention of disease.

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NEGLECT IS YOUR HEALTH'S WORST ENEMY



Are YOU Guilty?

You probably are! . . . Your doctor cannot seek you out and offer you his help. The ethics of his profession forbid that.

All he can do is to wait for your summons.

He is prepared, not only to help those who are actually ill, but also to prevent illness in those who are apparently well.

Why call upon him NOW? Here are reasons:

- 1. Millions of men and women are well, but not so well as they might be. You may not actually be sick but at the same time you may not be enjoying buoyant health. An examination by your family doctor is the best possible way to get the utmost out of your good health possibilities.
- 2. Physically and psychologically, you are an *individual*. A health examination will enable your doctor to learn your constitution, temperament, and tendencies. If you should become ill, this knowledge will be of great help to him. The more

he knows about you the more he can help you.

- 3. You probably have certain weak spots in your health-armor. Your doctor can find these spots and strengthen them *before* disease attacks you.
- 4. Disease germs are everywhere. You can't avoid contact with them. But your doctor can take certain steps to protect you against contagious diseases.
- 5. You may have a number of fears about your physical health which are real to you, but which your physician may prove actually baseless. Many of us make ourselves ill by useless worry.

Neglect is your health's worst enemy. The most important step in the battle is to go to your doctor before he has to come to you.

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The World's Largest Makers of Pharmaceutical and Biological Products

her sisters who have the same problems, the same object, the same hopes. The first step is the county view, where the county auxiliary is the clearing house for an increased friendliness and cooperation among the families of the medical men whose work lies within its boundaries. The state-wide view brings its greater problems as well as its increased pleasures, for the same laws govern all, climatic and political handicaps are similar, and friendly contacts and opportunities for service are even more interesting. But it is as a national association that the Auxiliary has its broadest program. Under the direct supervision of the American Medical Association, its program is carefully planned to fill the needs of its varied members and its different departments offer information and opportunity to interested workers.

This loss of the narrow viewpoint is a most stimulating result of Auxiliary membership. Living so closely with the medical profession as we all do, its disadvantages, its denials, its demands. loom so large in the foreground that its forward vision and steady accomplishments are often overshadowed. Auxiliary membership brings us into this broader view, makes us more medicallyminded, so to speak. A member realizes not only the need of the profession it serves, but becomes more aware of the health consciousness of the public. There is hardly a group of organized women, or men either, in this country which does not have some health work as part of its national program. This alone shows the need of informed and understanding women, and the Auxiliary undertakes to supply this need, not only among its own members, but in the dissemination of health information among other women's organizations. An Auxiliary member, through the national, state, and county study programs, becomes better equipped to answer this public demand, and gains an immense amount of private satisfaction through increased knowledge and interest.

Medical history is another virgin field. Every state, every county, and every community has its unsung heroes of the profession, a record of whose undertakings and accomplishments would be an inspiration to those in the midst of the work now. It is the women who must look back for these records, compile them, and save them for the future. This is the particular aim of the Auxiliary to the Southern Medical Association.

But let it not be supposed that auxiliary membership means all work and no play. Organized originally for friendly social meetings, these are



Heartily agreed

... but what if they refuse to drink milk?

A CERTAIN State Department of Public Health is greatly exercised over the fact that malnutrition among children seems to be on the increase.

In the state referred to, many localities are furnishing the school children hot soup at noon. This explains the outburst of the Health Commissioner quoted above. He ends by saying: "Soup has its place . . . but let's give our growing children milk, and lots of it."

BUT..."you can lead a horse to water, etc."... and children are far more strong-minded than horses!

Here is where thousands of physicians have found Cocomalt of immense assistance. The youngsters frankly love this delicious chocolate flavor food drink, which is always added to milk. Even those who detest plain milk drink it eagerly.

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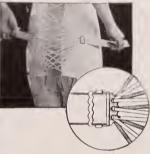
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still important, and each Auxiliary has as part of its program the entertainment of its own Medical Society. These gatherings of the men and women are always high spots of pleasure.

Neither is the wife any longer a mere hangeron at medical conventions. She has her own conferences and conventions now and her own friends from all over the country. The conventions of the Woman's Auxiliary to the American Medical Association are annual reunions for old friends and new. One has only to try one to be a confirmed addict. State and sectional meetings are equally enjoyable.

With these varied projects, interests, and pleasures, can one fail to see an advantage in Auxiliary membership? It is not just "another organization" in this already over-organized world. It is the only woman's organization which has the good of the medical profession at heart. Should it not be the one to make the first appeal to all eligible women?

ADVERTISERS' NOTES

Lord Lister, experimenting with crude carbolic acid as an antiseptic in surgery in 1867, found that in avoiding the danger of infection he was encountering a new difficulty in superficial sloughing and death of tissues. In his paper on "The Early Stages of Inflammation" (1853) he had shown that the effects of irritation on the tissues are twofold: first, a dilatation of the arteries, developed through the nervous system; and second, an alteration in the tissues on which the irritant acts directly.

Capacity to destroy bacteria is a claim that can be made for many modern bactericidal agents even in very high dilutions. Agents that will accomplish the desired results, however, without injury to animals and animal tissues are comparatively rare.

From the Lilly Research Laboratories comes an interesting announcement of an organic mercurial compound, Merthiolate, said to compare favorably in bactericidal efficiency with the best of germicides now available and to be particularly distinguished by its extremely low toxicity to animals and animal tissues. The literature on Merthiolate states that the product is potent in the presence of organic matter, non-toxic and non-hemolytic for red blood-cells, non-irritating to tissue surfaces, non-staining, and stable in solution. Merthiolate should find a large field of usefulness among medical men.

RARE AMINO ACIDS NOW AVAILABLE

New information on feeding problems is expected to result from the announcement that The Research Division of S. M. A. Corporation is able to supply certain rare amino acids and other protein derivatives to research physicians and others interested in research in nutrition.

Research on many nutritional problems has been held back by the scarcity and high prices of some of these amino acids which are more costly than platinum.

Moreover, these amino acids are used up and destroyed in experiments, whereas platinum may be salvaged and used again and again.

Consequently the announcement of a new source of supply should give a stimulus to food research. The Research Division of S. M. A. Corporation in making the announcement expressed the thought that the prices of these rarer chemicals may ultimately be brought within the range of any research budget.

AN OPPORTUNITY TO EARN \$15,000

Mead Johnson & Company announces an award of \$15,000 to be given to the investigator or group of investigators producing the most conclusive research on the vitamin A requirements of human beings.

REQUIREMENTS

Candidates for the award must be physicians or biochemists, residents of the United States or Canada who are not in the employ of any commercial house. Manuscripts must be accepted for publication before December 31st, 1934, by a recognized scientific journal. Investigations shall be essentially clinical in nature, although animal experimentation may be employed secondarily.

COMMITTEE ON AWARD

The Committee on Award will consist of eminent authorities who are not connected with Mead Johnson & Company, the names of whom will be announced later.

SOURCE OF SUPPLIES

There are no restrictions regarding the source of Vitamin A employed in these investigations.

For other details of the Mead Johnson Vitamin A Clinical Research Award, see special announcement, pages 14 and 15, in Journal of the A. M. A., January 30, 1932.

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

		1	MF	ETINGS		
COUNTY	SECRETARY	Date	Time	Place	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Bay	D. M. Adams, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Chamber of Com- merce	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambla	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madlson	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando- Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg.	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Thursday	12:15 P.M.	Eldorado Cafe	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
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VOLUME XVIII

Jacksonville, Florida, April, 1932

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Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

NEXT SESSIONS, FLORIDA MEDICAL ASSOCIATION. SARASOTA, MAY 3-4, 1932

AMERICAN MEDICAL ASSOCIATION, NEW ORLEANS, MAY 9-13, 1932

ENRICHED WITH MINERAL AND VITAMIN CONTAINING FOODS

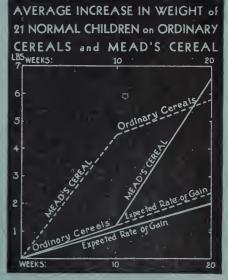
SIMPLY by the addition of 4 ounces of Mead's Cereal to their daily diet, a group of 10 children studied by Summerfeldt¹ gained at 4.84 times the rate of a control group fed on ordinary cereal. Yet when the first group were fed ordinary cereals they gained at only 1.17 times the expected rate.

These results are highly significant considering that the patients to start were of normal weight and were receiving an optimum diet and hence would not be expected to respond as well as a group of underfed children.

The marked gains are attributed by Summerfeldt to the diet rich in vitamin B, in which Mead's Cereal excels. This palatable food also contains substantial amounts of 9 essential minerals, and given with orange juice and Mead's Cod Liver Oil, it supplies all the vitamins needed by the growing child.

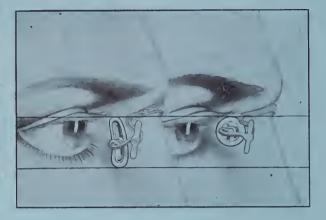
Summerfeldt, P.: Am. J. Dis. Child. 43:285-290; Feb. 1932.

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The comparison of the position of Bal-Guards and the old type pad is clearly shown in the accompanying drawing. The old type extends down over and rests on the nasal bone, often causing irritation and discomfort. Bal-Guards rest comfortably on the fleshy part of the nose—they do not extend down to the nasal bone. Bal-Guards are the only pads offering this feature.



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A modern neuropsychiatric hospital with special laboratory facilities for the study and treatment of early cases. Also a department for the treatment of drug and alcoholic addictions.

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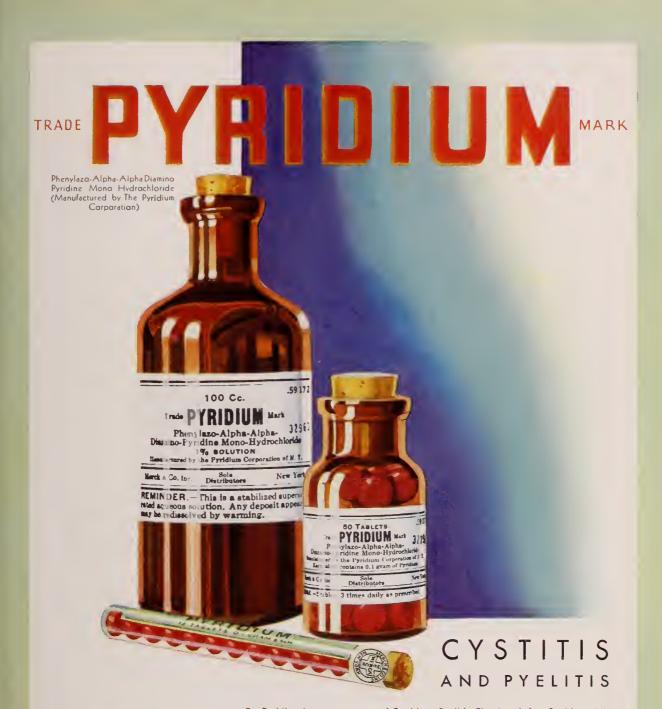
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CARDIAC DISEASES AND THEIR RELATION TO OCCUPATION*

T. Z. Cason, M.D.,

Jacksonville.

Scientific investigation, in its search for the obscure or hidden, may be carried to the point where the knowledge gained is of no practical value if it does not aid mankind, directly or indirectly, in spite of the difficult and tedious method by which it has been obtained. A review of medical literature yields little with reference to the effect of occupation on cardiac diseases.

The primary object of this paper is to urge the practical application of the knowledge gained through years of experience, through the use of the X-ray, the fluoroscope, the electro-cardiograph, and the polygraph, thus preventing the potential cardiac from becoming handicapped and aiding and directing the individual with the established heart lesion in order that his life may be more useful as well as prolonged.

It is evident that cardiac diseases are occupying more and more an important place in the realm of preventive medicine, in diagnosis, and in therapeutics in its broadest sense. Ability to make an earlier diagnosis, together with increased knowledge of the handling of the cardiacs, is of the utmost importance to the health and life span of the patient with early or potential heart disease.

As the much lower and lowering death rate from tuberculosis has to a considerable extent come about through early diagnosis and publicity, the same is becoming true with reference to cardiac diseases. This publicity, while directed at the layman, has affected the physician as well.

The effect of occupation on the established heart lesion is the first major phase of the subject I wish to discuss.

If a cardiac lesion exists, the most hopeful prognosis results if it is discovered in infancy before intensive child-play has begun, or in later life before an occupation has been chosen. Carried to its logical conclusion, this indicates that every child on entering school should present a certificate from a capable and conscientious clinician or should have an examination by a well-

trained school physician. At this stage of the child's life, only two cardiac conditions are likely to be present: first, the congenital heart, and second, the rheumatic heart.

When a child is born into a well-to-do family, or at one of the modern, well-regulated charity hospitals, it is generally seen shortly after birth by a pediatrician. This is particularly true if the newborn presents any anomalies. Consequently, if such a child has a congenital heart lesion, it is studied almost from birth. This group of lesions is but a small percentage (variously estimated from 1% to 3%) of the cardiacs. The majority die fairly early and thus they are not a problem for child guidance or occupational election. A correct diagnosis of the congenital heart lesion would lead to a longer and more comfortable period of life.

When it is discovered that the child has developed a heart lesion, a careful study should be made to ascertain the amount of involvement, the extent of the damage, and the potential handicap. This, as a rule, can not be determined until some months after the original infection. As soon as this is done, if the child is old enough, his education and that of his parents should begin. The amount of play, rest, and when these are to be taken should be outlined by the physician. The school teacher should be fully acquainted with the child's condition. If the lesion is not too severe and the regime carefully carried out, it is highly possible that by the time the child has reached college, light gymnasium work may be carried on.

Whether the individual be girl or boy, the question of choosing a life occupation is an important one. Because rheumatic heart disease in the South, particularly in the far South, is proportionally much less frequent than in the North, especially in the New England states, the child who has such a condition should, in my judgment, be urged to take his college work in the South and to elect an occupation whereby permanent residence may be maintained in the South. In the selection of life occupation, the chronic cardiac should take into consideration the amount of physical work to be done, the places to which it

^{*}Read before the Chattahoochee Valley Medical Association, July, 1931.

will carry him, and the possibility of taking rest when needed.

The problem that will confront us most often as physicians is that of the person with a cardiac lesion already engaged in gainful occupation. The congenital heart lesion has usually been previously diagnosed; however, if present and not diagnosed. the type must be determined. Certain of these congenital lesions are of an anatomical interest rather than a physical handicap. Those with more serious pathology seldom live to reach the period when self-support begins. The most common lesions we shall see are the rheumatic, among which are included chorea and endocarditis following acute tonsillitis, and the syphilitic heart. In the group of states comprising New England, the rheumatic heart is decidedly the most frequent, while in the South we are apt to see most frequently the syphilitic heart, particularly those of us who serve in general and charity hospitals. White in his recent book, (Diseases of the Heart, chapter XIII, page 322) says, "One of the most important and difficult problems of medicine today is that of rheumatic heart disease. Although in tropical and semitropical climates this type of heart disease is not frequent, in many thickly settled communities of the temperate zone throughout the world it is the most serious of all types. Not only is it the most common type, but it is one of the chief scourges of youth, crippling and killing children and young adults."

Those of us who were educated in the South and have practiced here must find it difficult to realize the significance of this disease where it is prevalent. Too, I suspect we frequently fail to recognize it. Failing to recognize it very early, we frequently do not prescribe the necessary treatment at the critical period. Where the rheumatic lesion is severe and the patient is engaged in heavy physical labor, the physician should not hesitate to insist on a change in occupation even though the change might mean serious financial loss. This applies equally to the syphilitic heart. All of us have seen numerous cases in the colored race where weeks of rest and proper therapeutics have established a broken compensation permitting the patients light exercise, only to have them leave the hospital to become stevedores or to do some other form of heavy labor. This would result in quick return to the hospital ward to go through the same process at attempted restoration. One or two repetitions of this and your patient can not survive.

The last condition to give us concern where a

change of occupation may prove of value is that of coronary occlusion. This condition occurs in the business executive, the highly trained professional man, and even in the sedentary thinker with hypertension. It is probable that our mode of living has materially increased this type of case. Our ability to diagnose correctly due to better interpretation, together with the use of the electro-cardiograph and our more careful clinical examination, indicates this condition to be much more frequent than we previously supposed. In such instances, it is necessary to limit the individual's further activity markedly and at the same time to find occupation for an over-anxious mind. The scope of this paper precludes in this connection the more serious heart lesions.

The change of occupation by the person with a cardiac lesion already established can at most only extend the life of the individual and make that life more comfortable. The physician's real benefit to the race in this connection must be the result of his study of the effect of occupation on the potential heart lesion. Let it be understood that work and exercise are not etiological factors in heart disease. Where a known etiological factor is present already, the type of occupation may be a marked causative force in producing a serious heart lesion.

The first and undoubtedly the most common condition wherein a physician's knowledge and advice may be of value in this connection is the heart disease due to hypertension. There are two types of hypertension that produce the hypertensive heart disease; first, hyperpiesia, most commonly called essential hypertension, and second, simple hypertension. White says that fully 95% of the cases of hypertensive heart disease are due to hyperpiesia and most of the remainder to nephritis. Both of these conditions are diseases of middle life and beyond. I think I may say without fear of contradiction, though not without some argument, first, that the etiology of neither hyperpiesia nor hypertension is as yet definitely established, and second that no treatment by the use of drugs has proven to be of the slightest permanent value. Nor has any other treatment by any other method been of sufficient value to justify claims for itself. It seems clear, then, that if the physician be honest with himself, his chief value to his patients lies in his ability to maintain a pleasant attitude of mind on the part of the patient and to regulate his physical activities. Common sense would necessarily include in this

simple regime a suitably balanced diet. The physician should go carefully into the day's activities and then regulate work, play, and rest. An absolute change of occupation may not be necessary. If a change seems advisable and can be accomplished without undue sacrifice, it should be made.

With me the most difficult problem in handling the hypertensive heart disease is when it exists in the housewife. Naturally, it is most difficult to change her occupation. Her routine is well established and little can be done to alter it. The physician can regulate the rest and play period and frequently advise changes that will be of benefit. It is well understood, however, that despite our supervision and direction, the course of the disease is constantly downward. Until we learn enough of the etiology to prevent hypertension, little hope can be held out except for prolongation of life.

Of toxic conditions producing a cardiac involvement, the goitre is a definite one. If the heart muscle has suffered unquestionable damage where the person is engaged in work requiring marked physical exertion, he should be advised immediately to change occupation. Before such a change is made, the physician should estimate as nearly as possible the heart muscle reserve. Upon this estimate he should base his opinion as to the type and hours of work the individual may be allowed to do. It is apparently an established fact that toxemia per se does not do permanent injury to the heart muscle. It is the condition under which the heart labors during the toxic period which causes the damage. The toxic goitre may then be an insidious cause of future trouble.

It is my opinion that teeth and tonsils, except as an avenue of bacterial invasion, have not proven to be a contributing factor in heart disease.

Frequently in routine examinations we find a definite murmur of the mitral or aortic valves in an individual who was not aware that such a condition existed. Careful inquiry will generally reveal the information that sometime in the past life there was an attack of acute rheumatic fever, chorea, or one or more acute attacks of tonsillitis. Voluminous statistics have been published within the last two years apparently demonstrating that the removal of tonsils seldom prevents a recurrence of these diseases. All of us have seen an endocarditis during or immediately following an attack of acute tonsillitis. This attack was unquestionably comparable to the rheumatic fever found so frequently in the north

temperate zone. Until the causative factor of these conditions is more definitely established, the removal of the tonsils in such cases should always be advised. Recovery may be so nearly complete that a few years later it is most difficult to determine the damage done. Where all these facts are known, the individual should be handled as one having a damaged heart. Where the occupation requires heavy manual labor or heart strain, the nature and possibilities of future heart trouble should be discussed frankly with the patient. He should be urged to change his occupation to a more sedentary one.

My studies have indicated that every case of untreated syphilis is a potential case of serious heart disease. Along with untreated syphilis should be included inadequately treated cases. In a recent study* of 864 consecutive cases of syphilis, 138 were definitely cardiac. The object of this study was to prove that the spirochaeta pallida do not have a predilection for the negro any more than for the white. In making this study I separated the cardiac and non-cardiac syphilities into colored and white, male and female, and finally into those doing light and heavy work. The same percentage of whites develop cardiac syphilis as do negroes. Among the whites doing heavy work, 21% developed cardiac syphilis, while among those doing light work, 11%. Among the colored doing heavy work 18% developed cardiac syphilis, while of those doing light work only 9% developed the cardiac form. The number of cases studied is sufficiently large to justify the drawing of conclusions: namely, that there are two definite relations in the development of heart disease, first, the interval elapsing between the time of contraction and the time of treatment; and second, the occupation of the individual.

Unquestionably, then, the cases of syphilis which have been for a long time either untreated or inadequately treated should be regarded as potential cases of heart disease. Even though the lesion can not be demonstrated the patient should be warned as to the possibilities and his chances of developing a serious heart lesion if heavy work is continued. Unfortunately, the large preponderance of these cases are negroes. It has been considered necessary that they continue to do heavy manual labor. We must decide whether it

^{*}The American Journal of Syphilis, Vol. XV, No. 4, p. 527, Oct., 1931. "A Comparative Study of Cardiovascular Syphilis in White and Colored Races." T. Z. Cason, M.D.

is economically sound to continue this policy or to provide light work for such individuals.

It becomes obvious that practical application must be made from findings resulting from research or this research may be valueless. It is equally true that our duty to the cardiac no longer is merely that of diagnosis and the administration of drugs. The heart lesion must be discovered early. A general knowledge of the patient's mental training, ability, his working environment, and other personal characteristics must be among the information gained. We must go much farther and determine not only the etiology where this is possible, but other predisposing causes such as occupation. Through publicity of the right kind and personal contacts with our patients, we must educate the public to a consciousness of the importance of caring for the established heart lesion and preventing as far as possible the potential heart disease. Finally, in untreated and improperly treated cases, syphilis becomes a potential case of heart disease; and that occupation is a factor in producing syphilitic heart disease. These cardiac cripples become economic losses to the community as well as handicapped individuals.

A PARTIAL STATISTICAL STUDY OF 365 CASES OF APPENDICITIS* J. S. Turberville, M. D., Century.

The high mortality of delay and mismanagement in acute appendicitis is my excuse for inflicting upon you this paper.

Being a "cross-roads" surgeon, I have had an opportunity to observe neglect and mismanagement to an unusual degree. Also it has been my good fortune to almost span the period of the inception and the development of the surgical treatment of appendicitis. It is a pleasure to look backward and see how far we have come. At first, most of the cases were perforated and had formed abscesses. In the earlier cases, the importance of protecting the peritoneum from soiling was not recognized and I fear it is still not given the place in technique that it deserves.

This study does not include appendectomies done during other operations, or in cases usually labeled "acute abdomen." Therefore, only those cases have been considered that had enough evidence to warrant the diagnosis of appendicitis before operation. The cases have been grouped

after the general statistical statement according to the macroscopic pathological appearance of the appendices presented at the operating table.

An attempt has been made to coordinate the time factor and other factors with the degree of pathology. The initial pain site has been studied in relation to nausea and vomiting and the situation of the appendix as found at operation. The relation of symptoms, laboratory and physical findings to the pathology in the appendix and surrounding structures has been studied.

A list of the things that should be known about every case of appendicitis was made, the records were searched and the items put under their respective heads. It was soon found that the records were very incomplete, the most complete being the operative records. It was pleasing to note, however, that the information recorded improved from year to year, and the last few years has come pretty near to the ideal. You will notice that the calculations were often not based on the whole series, but on the number that had this information.

There was surprise at the average number of hours elapsing between the beginning of the illness and the operation, especially as the practice has been to operate as soon as the diagnosis is made. There were very few exceptions to this rule. This has been due, I think, to the great distances of many of the patients from their doctor and from the doctor to the hospital. Nearly all of my own, and those of my near neighbors, have been operated upon within twenty-four hours. An effort has been made to teach the doctors the importance of early diagnosis and early treatment, but it has borne very little fruit. You will notice, however, that the mortality is not so dependent on the time element, except as time generally increases the pathology, as it is to the degree of damage done to the appendix and surrounding structures. The time element must be stressed as there is no way of telling how rapidly or how slowly the pathologic process is progressing and, besides, it is the only element over which we have any control.

Treatment: The following routine treatment was employed: Right rectus incision in almost all cases. If there had been any delay, or the symptoms and laboratory findings indicated the probability of gangrene or perforation, the greatest gentleness was used in locating the appendix, and if the sense of touch indicated recent adhesions or abscess formation, the fingers were kept in

^{*}Read before the Chattahoochee Valley Medical Society, July, 1931.

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touch with the pathology to act as a guide while warm moist sponges were used to isolate the appendix and its consequent pathology. No attempt was made to remove the appendix until the surrounding structures were protected. mesentery of the appendix was ligated, in sections if thought necessary, cut from the appendix, the latter crushed at its base and ligated. The base was then surrounded with a purse-string suture, the appendix clamped with two forceps distal to ligature and cut between with a knife dipped in 95% phenol. The proximal clamp was then removed and a small forcep used to spread open that portion of the stump that projects beyond the ligature, the mucosa thoroughly phenolized and this neutralized with alcohol. The stump was turned in by the purse-string suture, and the mesenteric stump tied down over the infolded appendix stump by the ends of the purse-string suture. Number one plain cat-gut is used for the appendix stump and number 0 chromic for pursestring. I think the mesenteric stump should, when possible, be anchored to the infolded appendix stump to prevent stripping it from the cecum by vomiting or gaseous distention, and thus favor its perforation or adhesions to its surface.

No hesitancy is felt in changing this procedure to meet the changing relations. If the appendix is fused to the cecum or the mesentery is too short to ligate, it is enucleated by incising the serosa along the anti-mesenteric aspect, and bluntly dissected from its bed. The stump is buried in the usual way and the appendix bed sutured, and infolded by a second suture if the cecum is much

damaged. Most of the appendices are removed in abscessed cases. By extreme care to prevent further soiling or spread of infection nearly every appendix can and should be removed.

Drainage is used where there is frank soiling and in abscess cavities, but this is confined to soiled or infected areas. I think it is bad practice to routinely put tubes in the pelvis and along the colon to the kidney pouch, unless these areas are soiled or infected. No rubber tube drain should be allowed to remain undisturbed for longer than forty-eight hours. The tube should then be removed by cutting off from one-half to one inch each day. Fenestrations should be small and the tube rotated a complete circle in order to dislodge granulations, omentum and appendices epiploicae. Effort is made at all times to avoid touching the sides of the wound with the inflamed appendix, but never to the extreme of handicapping the operator in his manipulations. All patients are operated upon as soon as the diagnosis is made, unless they have been sick for some time or are very fatigued from a long journey. I think there are very few times when patients are too sick to be operated upon if there is some preparation such as hydration carried out. Meticulous care is practiced in closing abdominal wounds.

Post-operative treatment is usually very simple. A pint of saline by bowel is given while the patient is on the table. No water is allowed until after six hours, then hot in sips. If this does not nauseate or cause vomiting in an hour or two, tap water is given. If patient does not vomit, water is allowed freely for forty-eight hours. At the end

CONCESTED INFLAMED ACUTELY INTIGNIGRENOUS 70 59 106 55 19% 10.7% 29% 14%. Condition- of- Appendix when-found-in-cr- total	CAPE CAPE	
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of forty-eight hours an enema of soap suds or bicarbonate of soda is given. If effective, fruit juices or broths are given at four-hour intervals for the next twenty-four hours. Another enema is then given, and if effective, light food is begun. Gaseous distention or vomiting are treated as they arise. We try at all times to not overtreat the patients. Purgatives and laxatives are rarely given while the patient is in the hospital.

I wish to acknowledge the help of my wife and Mr. J. R. Bradley, Jr., in the preparation of this paper. Really, the detail has all been done by them, my task having been almost wholly directional. Mr. Bradley is entirely responsible for the charts and graphs and the written explanations of them. No attempt has been made to review the literature of the subject. Therefore, I do not know by comparison what my results should be.

EXPLANATION OF APPENDICITIS CHARTS

These charts cover a period of ten (10) years, from 1921 to 1930, inclusive, considering a total of three hundred sixty-five cases. Complete data were missing in many cases, especially the preoperative data; however, all available data have been tabulated and coordinated to secure the following tables and graphs. All data were tabulated just as found in the pre-operative and postoperate hospital records.

Beginning at the upper left hand corner and moving toward the right, we find that, 328 or 90% of the cases were white; 36 or 10% colored; 1 not mentioned. 205 or 56.3% were male; 159 or 43.7% female, 1 case not mentioned. 142 or 42% were married; 196 or 58% single; 27 cases not mentioned; of the last series, the 338 cases married and single were used to arrive at a percentage basis.

The condition of the appendix was found to be congested in 70 or 19% of the cases; slightly inflamed in 39 or 10.7%; acutely inflamed in 106

or 29%; gangrenous in 53 or 14%; ruptured in 65 or 18%; abscessed in 11 or 3%; normal in 1 or 0.3%; not found in 20 or 6%.

Out of 365 cases 92 or 25% had localized peritonitis; 19 or 5.2% had general peritonitis.

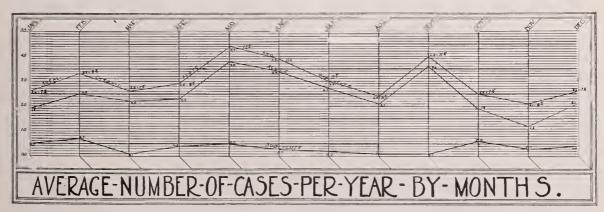
Considering the 365 cases as to type we find 24 or 7% chronic; 296 or 81% acute; 42 or 12% sub-acute.

72 or 20% of the cases were suppurative; 13 or 3.6% were both suppurative and gangrenous; 11 or 3% died.

Coordinating the hours of illness before operation in the acutely inflamed, sub-acutely inflamed and ruptured cases, we find that in 66 cases acutely inflamed the average hours sick were 45.4; in 12 cases sub-acutely inflamed the average hours sick were 87.6; in 31 cases ruptured the average hours sick were 114.5.

We next consider the perforated or ruptured cases and average hours sick of those who did and did not have purgative. We find that 36 had purgative, 12 of these or 33 1/3% were ruptured, and the average hours sick were 105¾. 130 did not have purgative, 20 or 15.8% were ruptured, and the average hours sick were 124.6.

Data regarding the blood count, both total and differential, were very incomplete. However, those avaliable have been combined and coordinated to arrive at a fairly accurate average. In 85 acute cases the W. B. C. were given in 81 for an average of 13,097, the polys. in 79 cases for an average of 81%. In 28 sub-acute cases the W. B. C. were given in 25 cases for an average of 13,427, the polys. in 21 cases for an average of 81.5%. In 42 gangrenous cases the W. B. C. were given in 38 cases for an average of 13,957, the polys. in 33 cases for an average of 83%. In 51 perforated cases the W. B. C. were given in 46 cases for an average of 22,880, the polys. in 35 cases for an average of 82.7%.



We next consider the errors in diagnosis. Taking the pre-operative first we find, 195 diagnosed as acute; 22 as sub-acute; 24 as chronic; 30 with some complication in connection with the appendicitis; 20 where the location of the appendix was named; 53 as ruptured; 5 as gangrenous. In the post-operative diagnosis 132 were diagnosed as acute; 33 as sub-acute; 18 as chronic; 42 with complications; 20 were found where named in pre-operative diagnosis; 81 were ruptured; 36 were gangrenous. There was quite a bit of overlapping in all cases both pre-operative and postoperative. Only the most important feature of the case was considered. For example, a case diagnosed as acute appendicitis, gangrenous and perforated, was tabulated as perforated.

Considering the table of occupations of patients, we find, 70 or 19.1% were school girls; 62 or 17% housewives; 59 or 16.1% farmers; 58 or 15.9% school boys; 49 or 13.4% occupation not mentioned; 14 or 3.8% common laborers; 10 or 2.7% children under school age; 7 or 1.93% clerical workers; 6 or 1.66% school teachers; 4 or 1.1% nurses; 4 or 1.1% merchants; 4 or 1.1% preachers; 3 or 0.83% salesmen; 3 or 0.83% mechanics; 3 or 0.83% railroad workers; 2 or 0.56% painters; 1 or 0.28% doctors; 1 or 0.28% sheriffs; 1 or 0.28% brick makers; 1 or 0.28% carpenters; 1 or 0.28% saw mill men: A total of 365 cases considered.

Considering the complications, we find that in the acute cases there were one case each, fecal fistula, bronchitis, fever, cerebral hemorrhage, general peritonitis, round worms, malarial infection; two cases bilateral salpingitis, right cystic ovary, left pus ovary; 14 cases wound infection. Sub-acute cases, one each, frontal sinus infection; wound infection. Gangrenous cases, one case each, peritonitis; obstructed bowel; concurrent cholecystitis; convulsions; 12 cases wound infections. Perforated cases, 3 cases fecal fistula; 2 cases pneumonia; 3 cases peritonitis; 1 case pelvic abscess; 1 case hook worms; 59 cases wound infections.

We will next consider the ages of the patients by decades from one to eighty, inclusive. Age from 1-10, 34 or 9%; 11-20, 124 or 34%; 21-30, 77 or 21%; 31-40, 35 or 9%; 41-50, 21 or 6%; 51-60, 13 or 3%; 61-70, 5 or 1%; 71-80, 4 or 1%. Age not mentioned, 52 or 16%. From the above table and from the graph it will be noticed that the highest percentage comes between ten and

thirty. Of these, the highest is between ten and twenty, 124 or 34%. From there our line has a gradual decline.

We will next consider "The Site of the Initial Pain in Relation to the Location of the Appendix." The site of the initial pain was in the epigastrium in 44 cases. Of these 82% or 36 were nauseated or vomited, 3 were extra caecal, 4 were pelvic, 66% or 29 were mesial, 4 were not found, 4 were not mentioned.

Umbilicus in 32 cases: 91% or 29 were nauseated or vomited, 4 were extra caecal, 3 post-caecal, 2 retro caecal, 2 pelvic, 53% or 17 mesial, 1 was anterior, 1 extra colonic, 2 not mentioned.

Right abdomen in 29 cases: 45% or 13 were nauseated or vomited, 3 extra caecal, 1 post-caecal, 69% or 20 mesial, 2 not found, 3 not mentioned.

Right lower abdomen in 38 cases: 47% or 18 were nauseated or vomited, 1 extra caecal, 2 post-caecal, 1 retro caecal, 2 pelvic, 61% or 23 mesial, 2 extra colonic, 2 not found, 5 not mentioned.

General abdomen in 24 cases: 71% or 17 were nauseated or vomited, 3 post-caecal, 75% or 18 mesial, 1 extra colonic, 2 not mentioned.

Right iliac fossa in 1 case, nauseated or vomited, mesial.

Pelvis in 1 case, nauseated or vomited, mesial. Lower left abdomen in 1 case, nauseated or vomited, location not mentioned.

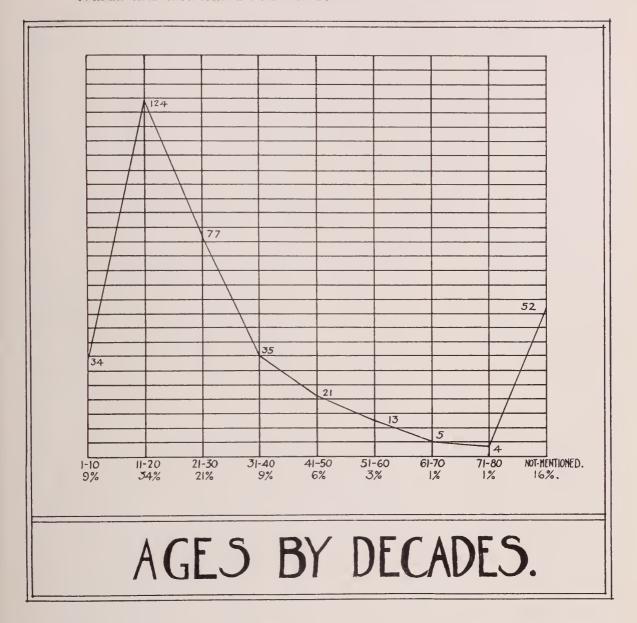
Left side, high up 1 case, nauseated or vomited, pelvis.

Chest in 1 case, nauseated or vomited, extra caecal.

A total of 172 cases gave the initial pain and sufficient data to coordinate with the location. Summarizing the above we find that 68% or 118 were nauseated or vomited, 7% or 12 the location was extra caecal, 5.3% or 9 post-caecal, 1.7% or 3 retro caecal, 5.3% or 9 pelvic, 63% or 109 mesial, 0.6% or 1 anterior, 2.4% or 4 extra colonic, 4.6% or 8 not found, 10% or 17 location not mentioned.

Considering the chronic, acute, and sub-acute cases per month over a period of ten years we arrive at the result shown on the accompanying chart or graph. The lower line represents the sub-acute cases. We have here a fairly straight line, with a high of 0.7 cases in February, fairly uniform until October when we get another peak with an average of 0.6 cases.

The center line represents the acute cases. In January we have an average of 1.9 cases, in February 2.5 cases, March 2.2 cases, April 2.3



cases, May a peak of 3.8 cases, June 3.4 cases, July 2.7 cases, August 2.1 cases, September another peak 3.6 cases, October 1.9 cases, November 1.2 cases, December 2.1 cases.

The top line represents a total of the chronic, acute and sub-acute cases. The chronic were not taken separately due to the small number. The percentage was worked out only for the total as the line is practically parallel with the acute line and the sub-acute totals were so small that a percentage comparison would be negligible.

January 2.6 or 7%, February 3.3 or 9%, March 2.6 or 7%, April 2.9 or 8%, May a peak of 4.4 or 12%, June 3.9 or 11%, July 3.0 or 8%, August 2.4 or 6%, September a peak of 4.0 or 11%, October 2.5 or 7%, November 2.1 or 6%, Decem-

ber 2.6 or 7%, month not mentioned 0.2 or 1%. You will notice that the peaks come at the beginning of the summer and fall, in May and September.

SUMMARY OF MORTALITY CHART

Considering the 365 cases of appendicitis from the point of mortality, we find that for the ten (10) years 1921-1930 there were eleven (11) deaths, or only 3%. One significant point noted during the tabulation of the data was, that, of the eleven deaths, not one had been during the last three years.

Summarizing the chart we find that of the eleven deaths, 10 were white, 1 colored; 7 male, 4 female; 2 children under six, 2 school children, 3 farmers, 2 housewives, 1 laborer, 1 not men-

tioned; 3 were married, 7 single, 1 not mentioned; 2 had previous attacks.

Acute appendicitis was the pre-operative diagnosis in all cases, and was said to be perforated in 5 cases, with peritonitis mentioned in two. The condition of the appendix was gangrenous in 3 cases, perforated in 3 cases, abscessed in 3 cases, I case not mentioned, I case normal with large mesenteric tumor, I case very hard cystic and purulent. Seven cases had localized peritonitis, 3 general peritonitis. The surrounding structure was bad in all but two cases. Drains were placed in all but two. Three were drained without removing the appendix. Six cases were suppurative, one both suppurative and gangrenous, 2 not mentioned. Four cases had wound infections, 1 badly infected. Six had post-operative distentions, 7 vomited after 12 hours, 7 had proctoclysis, 7 hypodermoclysis.

The cause of death was, peritonitis in 3 cases, general peritonitis in 4 cases, exhaustion from vomiting in 1 case, cerebral embolus in 1 case, septicemia in 1 case, general peritonitis gastric hemorrhage in 1 case. The post-operative diagnosis bore out the pre-operative diagnosis to a marked degree as shown on the chart.

The complications entering the cases were, fecal fistula separation of the abdominal walls; mesenteric tumor; 2 cases peritonitis; 2 cases general peritonitis; cerebral embolus; wound infection, peritonitis, toxic insanity; death; general peritonitis, gastric hemorrhage; general peritonitis, miscarriage.

One case pre-operatively diagnosed as appendicitis was found to be a mesenteric tumor too large to be removed. The patient died from exhaustion from vomiting. Note second case on chart.

OTOLOGIC IMMUNITY* C. J. Heinberg, M.D., F.A.C.S., Pensacola.

It has often been noticed that in certain sections of the country the virulence of bacteria and certain physiological functions of the body differ because of climate and other local conditions, which affect both the human and the micro-organism.

Fulminating acute infections, such as those of the mastoid, are seen in our part of the south, but they are comparatively rare and not nearly so frequent per ratio of population as those in the colder climates; likewise, the very acute diseases of the paranasal sinuses. Even blood pressure averages are lower in warmer climates where the lack of extreme cold is causal of less heart effort.

The newborn inherits a natural immunity from disease but with the first breath begins to be exposed to influences which bring into play the complex mechanism of acquired immunity involving certain new and enhanced physiologic activities.

The specificity of germs in the etiology of accessory sinus disease has been vastly overstated; identical changes in the sinus wall, both gross and microscopic, showing different organisms on culture.

Much thought has been directed to the reticuloendothelial system in the repair process. The term is now much in use but its exact meaning is Rammer (1899) described certain branched cells with oval nuclei found in connective tissue generally and which he called clasmatocytes. He thought these cells modified hemic leucocytes and attributed to them both active phagocytic and food carrying properties. Marchand was later able to show that these cells were not modified leucocytes but true constituents of connective tissue, mainly of vascular adventitial walls. He referred to them as leucocytoid cells and was able to observe that in inflammatory conditions they became converted into macrophages and even into other forms of leucocytes. The reticulo-endothelial system is widely distributed through the body, especially in perivascular connective tissue. The whole process of infections calls these structures into action. Massive accumulation of reticuloendothelial cells may be caused within serous cavities by injection of heavy sterile oils and such thickening, experimentally produced in the peritoneum and pleura make these membranes impervious to a hundred times the dose of hemolytic streptococci quickly fatal in control animals. These factors in cellular defense are directed, in normal persons, against all sorts of extraneous dangers, irritants, and toxins. I have applied this principle to mucous membrane by using the Proetz displacement method of filling the sinuses. I have used an antiseptic with a glycerine base known as hexylresourcinal (St-37) and find the treatment particularly valuable in hyperplastic sinusitis, catarrhal sinusitis, and in the resolution stage of purulent sinusitis. In acute sinus disease when the ostia are swollen this treatment can be of no value.

Besredka's work with intradermal antivirus

^{*}Read before the Escambia County Medical Society, Jan. 12, 1932.

offered much, but unfortunately has been rather limited to dysenteria and pyodermal infections.

The so-called debility diseases, endocrine imbalances, avitamintoses, etc., all contribute to the biochemical and physical factors in otologic immunity.

It must be borne in mind that the exposed membranes of the nose and throat are endowed with a higher immunity than the mastoid and accessory sinuses.

The work of Proetz and others has shown that the mucosa of the antrum is resistant to physiologic function if not to disease. The reformation of the mucosa after thorough curettement and the preservation of the air currents towards the natural ostia after fenestration under the inferior turbinate demonstrates nature's attempt to preserve the normal.

Otologists have noticed that cases giving the same clinical symptoms and submitted to the same surgical procedures with grossly similar operative field findings eventuate in different outcomes. One case recovers; a second goes through a series of complications and dies; a third, its acute phase subsiding, results in a chronic lesion. We were at a loss to understand what differentiated one of these cases from another until Dr. L. G. Hadjopoulos of the Beth Israel Hospital, New York, revealed the answer.

Studies of pus from the canal and mastoid at operation, gave no information. The bacterial invader was always the streptococcus hemolyticus. Dr. Hadjopoulos differentiated one streptococcus from another of the same morphologic group and opened a new field to increase the patient's immunity to those grave types of streptococcic infection, and enhance the results of properly applied surgery. Any immunizing agent would have to act between the time of the purulent otitis media and its complicating sequelae, for when the latter develops the bacterial flora has already reached its specific characteristics.

The streptococcic flora has an intimate, though diversified relation with mastoiditis which has been considered a primary disease because of the disputed etiology of precursory diseases such as colds, etc. Histologically, the tympanic and mastoid cavities constitute a blind sac extension of the nasopharyngeal cavity. The enstachean tube affords a continuity to the mucosa of endodermal origin which includes all the mucosa of the ear except that of the internal ear which is of ectodermal origin and lined with epithelium formed

from it. Consequently, a study of the bacteriology of the nasopharynx naturally leads to the middle ear and mastoid via the eustachean tube. Again it must be borne in mind that the sheltered mucosa is not as resistant to infection as the exposed portions. The streptococcic flora of the nasopharynx and mastoid demonstrated the same three main types and therefore mastoiditis is to be considered a complication of pre-existing nasopharyngeal infection rather than a disease per se. Careful histories of mastoid cases usually reveal some previous respiratory infection such as colds, influenza, tonsillitis, etc.

The bacterial differentiation of this streptococcic flora as described by Dr. Hadjopoulos gives us four main groups.

The first, the obligate aerobics whose dependence on a free oxygen supply limits them to the exposed mucosa of the upper alimentary and respiratory tracts. They cause the acute catarrhal or congestive type of inflammation and sometimes hemorrhagic or necrotic. When they gain access to the middle ear there is acute inflammation with a red and bulging drum. The eustachean tube becomes swollen and closes, thus diminishing the oxygen supply and limiting it to that which osmoses from the hemoglobin of the blood. In a now closed cavity with a limitation of oxygen the process abates unless the tympanic membrane is ruptured, spontaneously or surgically, when there is relief of pain and signs of recovery. It is at this time that the streptococcus gains new virulence by reason of the oxygen supply and leads to hospitilization and surgical intervention. It has been my practice that where this organism is suspected the external canal is filled with boriodine powder if the drum has not ruptured spontaneously some time previously. This absorbs a small quantity of secretion and hinders oxygen from reaching the middle ear through the perforation; if the exudate is profuse, it will wash away the powder and itself occlude the myringotomy or perforation.

The second group, the facultative aerobe, is similar to the first group in its ability to survive under low oxygen tension but it penetrates deeper into mucosa and submucosa and ultimately results in deep-seated pyogenic infections requiring surgical intervention such as retropharyngeal and tonsillar abscess, recurrent paranasal sinus disease, etc. Ear complications are usually characterized by an intense throbbing earache, fever and a gradual accumulation of purulent exudate in

the middle ear. The drum is usually ruptured spontaneously before the physician is consulted but if seen immediately and before rupture occurs, it presents a white distended tympanum. The rupture of the drum offers symptomatic relief but the mastoid is invariably involved and the patient soon becomes very septic. In surgical intervention in these cases there is an almost complete disappearance of the cellular structure of the mastoid, whereas in the first group there was only thinning. It is in the second group cases that most of the complication of mastoid such as dural and epidural abscess, jugular thrombosis, etc., are found. The mortality rate in this group is high, being estimated at 35%. Early surgical intervention in these cases is highly important.

In the third group, the facultative anerobe, we find the normal habitat is the intestinal tract and they are usually anerobic but can preserve their pathogenicity under strictly aerobic conditions. They can be isolated in the upper respiratory and alimentary tract from the gums, dental caries, nasal sinuses, etc. They give rise to chronic inflammatory conditions with granulation tissue coverings.

The fourth group is the pneumococcus or streptococcus mucosus capsulatus. Type III is the one usually found in ear and mastoid infections. This class is very fatal with but little symptomatology at the onset. Fortunately it is comparatively rare.

Thus Dr. Hadjopoulos has explained why many otologic cases which have received the same treatment have different courses. This great worker has been able to prognose from a test tube that patients, having undergone an operative procedure, would recover, have complications, and in five instances he accurately prognosed death in cases apparently getting well without making any contact with the patient or their records.

As previously stated, fulminating nasal sinus and mastoid cases are rare in our particular section. Clinically we have found that most of our cases belong to the first group.

What effects climate has on the other type of organisms, whether or not it is a higher incidence of ultraviolet sunlight or whatnot—otologic immunity differs and treatment should be instituted accordingly.

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DISCUSSION

Dr. M. A. Lischkoff, Pensacola:

This timely paper is made more interesting by the practical application of its contents. We, in otolaryngology, are constantly being helped through laboratory aids, in diagnosis and treatment. For example, I mention the non-specific proteins and their use in our field.

Dr. J. N. McLane, Pensacolo:

I have often noticed that some cases where a simple paracentesis of the drum was done, and no further effort made to reopen it if it closed right away, that the patient got along better and I am glad to hear the explanation. I think we are too prone to open every drum where there is an otitis media. I have done some work with the antigens derived from the method of Besredka and can say that seven of nine patients were improved.

Dr. J. M. Hoffman, Pensacola:

I think the intradermal use of Besredka's antivirus should have more trial. In a case of pyelitis with a proven B. Coli infection it immediately cleared with an antigen of this specific organism. Another case of staphylococcus prostatitis cleared wonderfully with this treatment. It seems that in streptococcic infections its use is greatly limited and its greatest efficiency is in the two types I mentioned.

Dr. C. J. Heinberg, Pensacola (closing):

We all know the values of non-specific proteins in acute conditions. In regard otitis media, I do not think we should be more conservative in doing a myringotomy else our drum rupture in the more unfavorable location, but more care should be directed to the canal after the myringotomy is done. Also I would direct your attention to the importance of nasopharyngeal antisepsis in all upper respiratory infections in an effort to obviate ear complications. Besredka's theory has long been known but its practical application to otolaryngology is new. My results with its use have not been what I had hoped it would bring forth.

AN ESTIMATED AVERAGE OF AT-LEAST 20 PER CENT HOOKWORM DISEASE IN 98 SOUTHERN SCHOOLS

Chas. Wardell Stiles, Ph.D., M.D., Winter Park, Fla.,

and

Benjamin J. Collins, M.S., Washington, D. C.

There exists a widespread impression that hookworm disease in man has almost disappeared from the United States and that it is no longer a problem for the public health and the educational machinery of our country.

As examples: Very frequently men from different parts of the country remark that they understand or that they see by the newspapers that hookworm disease has been eradicated; the head professor of education in one of our prominent southern universities remarked in our presence that " we have been led to believe that hookworm disease no longer occurs in the South"; an unusually able (southern) county superintendent of schools remarked to us that this disease was not to be found in his county (but we showed him many cases the next day); in one town a United States official informed us that hookworm disease was formerly very common in that county and had been entirely eradicated (but we estimated 66 to 82 per cent infection in the local school).

During a recent (January-March, 1931) automobile trip¹ of 5524 miles in order to observe certain advances in public health in the Gulf-Atlantic States judged on a comparison with the conditions in 1902, we had an opportunity to observe thousands of white pupils of 98 schools and thus to test the validity of this more or less current belief in regard to the rarity of hookworm disease. Much as we would like to feel that this widespread impression is correct, we are constrained to state that it is not confirmed by theoretical considerations, by laboratory examinations, or by clinical observations.

Area included.—The school districts in which observations were made are within the area included by lines drawn from Washington, D. C., to Newport News, Va., to Key West, Fla., to New Orleans, La., to Jackson, Miss., to Augusta, Ga., to Columbia, S. C., to Pinehurst, N. C., to Raleigh, N. C., to Richmond, Va., to Washington, D. C. In other words, most of the observations were made in the sand lands and the loose soil lands, while very little of the clay lands and none

of the mountain counties were visited. The reason for this selection, from the viewpoint of hookworm disease, will be evident to any one familiar with the fact that it has been common knowledge for more than a quarter of a century that hookworm disease is more common in the sand areas than in the clay counties and in the mountains.

White schools.—The reason for selecting the white, instead of the Indian and negro schools, was that clinical observations on hookworm disease are much easier and much more trustworthy when based on whites than when based on Indians and negroes.

Method of work.—For the greater part of the trip we held to the through highways, namely to the "U. S." and the "State" routes; occasionally, however, side trips were made into isolated areas which could be reached only by the rough, old-time, unimproved, country dirt roads. Saturdays (when the schools are closed) and rainy days (when observations are less trustworthy) were usually utilized for long drives of 150 to 225 miles, thus forming a considerable break in the line of schools.

Constantly observing sanitary conditions and on the lookout for schools, we visited a reasonable number of the latter in different localities. Introducing ourselves to the principal, we explained the object of the trip; we were received with the greatest cordiality; in many cases the reception was even more than cordial, especially at schools which had had no medical inspection for one to three years. An outstanding fact was that school-teachers are enthusiastic believers in medical inspection.

We passed from room to room interrupting each class a sufficient time to ask a few questions (especially regarding ground itch), to count the pupils and to observe critically the condition of the children. In many cases the object of the trip was explained to the children, especially to those in the high school grades; the cordial cooperation on their part was a splendid commentary on their behavior and training.

Suspects.—Any person who has been associated with "dirt-eaters" can recognize one on sight, or at least can tell if a person comes within this category as interpreted by the laity. Not all "dirt-eaters" are hookworm cases, but the estimate is conservative that 90% of the so-called "dirt-eaters" in the Gulf-Atlantic States are cases of extreme hookworm disease. That many southern school-teachers are able to recognize one on sight

is shown by the fact that years before the widespread presence of hookworm disease was known for the Gulf-Atlantic States, a discussion took place in a teachers' training class in the University of South Carolina, on the possible cause of dirt-eating in children.

Any person who has extensive clinical experience with hookworm disease soon acquires a general picture of the condition which is as characteristic as is the picture of various other diseases (smallpox, tuberculosis, malaria, etc.), and on severe and characteristic cases there is only a remote chance of going astray in the symptomatic diagnosis.

Like other diseases, however, hookworm disease varies by imperceptible clinical gradations from the dirt-eating stage to exceedingly moderate and light manifestations in which the careful observer is not willing to commit himself definitely on basis of symptoms but suspends judgment pending microscopic examination.

To express it in other words, there are many persons who exhibit conditions which are entirely in harmony with hookworm disease but in whom the picture is not sufficiently distinct to warrant an unqualified and positive symptomatic diagnosis. These persons can well be classified as "suspects" sensu restricto.

The percentage of confirmation of "suspects" by microscopic examination varies with conditions under which the symptomatic diagnosis is made: namely, light (sunlight, gaslight, electric light), reflection of colors (buildings, walls, ceilings, curtains), weather (rain, cloudy weather, sunshine), age and sex of subject, race of subject (white, yellow, red, black), prevalence of other conditions and other diseases (especially undernourishment, ascariasis, and malaria in the same district).

We consider that our statistics contain a theoretical error (different for different schools) as low as 5% and as high as 30%, not including certain special groups (as the children of Key West, Fla.) in which we view our findings unreservedly as *sub judice*. For practical purposes, we willingly assume a general average theoretical error of 10 to 20%, on basis of former check-ups (cotton mill work) in which the error of the senior author (check up by the *smear* method) averaged about 17%. Our general thesis is that hookworm disease is still common and widespread in the area visited, but if the reader desires to deduct a second 20% from our gross figures, for

the sake of ultra-conservatism because of the disturbed economic conditions resulting in malnutrition, we raise no objection to his doing so, for even with the second deduction the residual estimate of about 20% still supports our thesis. But we consider our estimate of 26% as fairly representing the conditions observed.

In every locality, except Key West, in which we sought for hookworm disease we found a sufficient number of absolutely characteristic cases to establish our thesis without necessity for microscopic confirmation. In addition, we met many absolutely characteristic cases during various stops (for gasoline, meals, road-information) between schools, cases which confirmed our observations in the schools. On only two occasions did we unpack our microscope, *i. e.*, once in Key West,² where the diagnosis seemed uncertain, and on one other occasion when we wished to demonstrate hookworm eggs to a school nurse.

In addition, we were able to obtain local or state data on microscopic examinations for many of the counties visited, and in many cases the teacher or the local health officer, on seeing us select a suspect, would remark: "He has just been reported microscopically positive," or "He took treatment a few days ago." In one school where we estimated 79.5 per cent infection we learned later that the State laboratory had recently found 100 per cent positives on microscopic examination and that in the meantime some of the children had taken treatment.

To collect specimens from and to test all cases observed was not feasible, from a standpoint of time.

We have no hesitation in regard to presenting our conclusions based upon clinical evidence even without the microscopic confirmation in every case.

Practical application of statistics.—All that it is intended to show by the statistics given in this paper is that hookworm disease is still widespread in our southern states. No claim is made for mathematical exactness. Personally we would not have treated a single one of these cases (especially with carbon tetrachloride) without microscopic confirmation for we do not favor "masstreatment." In considering the mathematical data, it is well to hold the following points in mind:

a. As most of the schools were in the rural sand land and loose soil districts, the percentages

28.1

are undoubtedly higher than they would be if averaged with an equal number of children in the clay land and city schools.

- b. As light hookworm infection can be reciprocally confused with certain other conditions (especially *Ascaris*-infection, malaria, malnutrition) this fact tends to increase the number of suspects; an exact interpretation of suspect cases depends upon microscopic confirmation.
- c. As a child may be absent from his room or from the school when the inspection is made, this fact decreases not only the total number of pupils examined, but also both the positives and the negatives and necessarily results in lack of uniformity between the clinical suspects and the microscopic positives. Accordingly, mathematical exactness is excluded in work of this kind.
- d. As children of school age show a higher percentage of infection than that found when the general population is taken into consideration (approximately as 395 to 330 as applied to our southern states) these figures for white school children should not be taken as a general estimate for the entire population (all ages, whites, Indians, negroes.)
- e. As many microscopic positives escape recognition by brief symptomatic inspection this fact tends to reduce the number of suspects, thus balancing to some extent the theoretical error.

Summary of results.—The 98 white schools were widely scattered in seven states, but state lines do not come into consideration in this estimate as there is a wide discrepancy between the number of schools and of children observed in the individual states; for instance, Louisiana (7 schools with 1,030 pupils) and Florida (28 schools with 5,722 pupils). The totals for the entire area are all that are needed to support our thesis.

The exact percentages, plus or minus, are from our point of view trivial and inconsequential in view of the important fact (not generally recognized by the public) that the job of controlling hookworm disease in the United States has not been completed. The following is a tabulated summary of our results:

Total number of states visited	7
Total number of white schools involved	98
Total number of white children recorded18,	649

Fotal number of hookworm cases recorded (including dirt-eaters, severe, moderate, but characteristic cases, and suspects	
sensu restricto)	6,063
Percentage of children classified as hook-	
worm cases (ditto)	32.5
Lowest percentage for any one school	1.0
Highest percentage for any one school	98.7
Deduction of 20% (from 32.5) on basis of	
theoretical error	6.5
Corrected percentage	26.0
Additional deduction of about 20%, if desired, for sake of ultra-conservatism	6.0
Final ultra-conservative estimate of lowest	
approximate percentage of hookworm	
cases	20.0
CC.C.,	20.0
For Comparison: ³	
Total number of persons (all ages, all lo- calities, all races) examined microscop-	
ically in 1929 by 9 southern state Boards	
of Health	21,388
Total number of positive for hookworms.	
The state of the s	,

CONCLUSIONS

Percentage positive

Hookworm disease is still very common and widespread among southern school children. The job of eradication has not been completed and probably will require three generations more of persistent work. It is wise to face the problem squarely.

REFERENCE

¹The senior author spent a large part of his time from September, 1902, to July, 1920, in field work in the southern states and was able to observe clinical, economic, and sanitary conditions. The recent (1931) trip is the first opportunity he has had since 1920 for similar extended observations in the part of the country under discussion.

²Despite the cooperation on the part of the principal, it was impossible to obtain specimens from suspects (except one, which was microscopically negative). Specimens from three non-suspects were negative.

After the nurse had observed our method of work in the schools she was requested to obtain specimens from children whom she would select as suspects but whom we had not seen. Of 5 specimens she collected, one was negative, 4 were positive for hookworms, and 2 for Ascaris lumbricoides. Thus, this nurse had a theoretical error of only 20% on symptomatic diagnosis in five suspects.

3. Stiles in Public Health Reports, 1930, v. 45 (31), Aug. 1, pp. 1763-1781.



A Bird's-eye View of Sarasota

Sarasota, the Art Center of the South

Sarasota, with a personality that sets it apart from every other place in the world, is endowed with the four essentials that make life worthwhile: a perfect location; ideal climate; splendid accommodations; and every recreational facility.

We could tell you of the many attractions of Sarasota—the splendid play facilities, the miles of white sand bathing beaches, excellent fishing, beautiful parks and drives, golf courses among the best—in fact, everything that goes to make an ideal place in which to live; but, first of all, we want to tell you why Sarasota is destined to become the "Art Center of the South."

Representing the consummation of an ideal, the realization of a dream, the John and Mable Ringling Art Museum stands alone in its grandeur and magnificence; the finest achievement of the kind in America.

For here in Sarasota has been built by Mr. and Mrs. John Ringling the second largest art museum in the United States, housing a collection of paintings, sculpture, and works of art unsurpassed. In this museum is found the largest individually owned collection of Reubens in the world.

As one drives along the Tamiami Trail north of the city or upon the Bay Shore road, the imposing structure, which has been erected as a permanent memorial to the faith of these two, looms large and impressive. No other city of whatever size may lay claim to an institution of such magnificence.

It is the intention of the founders to have here the most liberal and best equipped school of art in America, and from this will unquestionably grow "The Art Center of the South." An important step in this direction was realized in the opening of the School of Fine and Applied Art of the John and Mable Ringling Art Museum in October, 1931. Sarasota is justly proud of this school, and with the stupendous Art Museum as a foundation, this institution is destined to become one of the outstanding art schools, not only of the South, but of the entire country. Adult classes for business men and women are proving very popular and more and more Sarasota citizens, citizens from nearby communities, and visitors from far and wide, are beginning to realize the vast importance of such an institution. In centuries to come, this school will remain a tribute to the vision and faith of John and Mable Ringling.

Sarasota, well equipped with splendid accommodations to suit every need, has foreseen the necessity of spacious accommodations for large groups coming here to view the museum and our other places of interest. The Mira Mar Auditorium, with a seating capacity of 500, is one of the most beautiful in the State. The American Legion Coliseum, built to take care of the everincreasing demand for a more spacious auditorium, to take care of Sarasota's conventions and larger groups of visitors, is well equipped and has made possible the entertainment of thousands of people each year. Sarasota is easily accessible by motor or bus line over the Tamiami Trail, 226 miles distant from Miami and fifty-four miles south of Tampa. Directly east lies the Sara Palm-



MUSEUM OF ART



Convention Headquarters, Hotel Sarasota Terrace

bee Trail, with direct route to the east coast. Sarasota is also served by the Atlantic Coast Line Railroad and the Seaboard Air Line Railway. A splendid airport for planes has been provided.

Florida is, without question, the healthiest State in the Union, and by actual experiment made in Sarasota County, it was found that there are 700 hours more of actinic rays of sun than are found in the most noted health resorts. Each year visitors from every state come here to enjoy "Nature's Solarium", which offers the nearest approach to perfect climate that can be found anywhere. If your health is good, you can build up a resistance here against future ailments that will add years to your life.

There are many other things we could tell you about Sarasota, but we need only to point out to you that this little city, according to 1930 federal census reports, stood highest in percentage of increase in population on the west coast of Florida and third in increase in the entire State.

Whether it is the colorful magic of the setting sun, the kindly climate, the palm-fringed beaches, the friendliness of the people, the inviting drives to many places of interest, we do not know. We do know there is something intangible, indefinable, that takes hold, and when once you are exposed to it you will want to stav forever.

PROGRAM OF THE THIRTEENTH ANNUAL MEETING OF THE

FLORIDA RAILWAY SURGEONS' ASSOCIATION OFFICERS, FLORIDA RAILWAY SURGEONS' ASSOCIATION

President, Thomas H. Bates, M.D	Lake City
Vice-President, George C. Tillman, M.D G	ainesville
Secretary-Treasurer, E. W. Warren, M.D	Palatka

COMMITTEES

Executive

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N.	A.	Baltzel	l, M.1	Э.											.Mar	ianna
C.	M.	Tyre.	M.D.												1	Eustis

Scientific

J. M. Irwin, M.D., Chairman	.St.	Augustine
T. M. Rivers, M.D		Kissimmee
J. Brown Farrior, M.D. (Deceased)		Tampa

Necrology

C. C. Webb, M.D.,	Chairman	Pensacola
L. M. Anderson, M.	D	Lake City
H. D. Clark, M.D.		Fort Pierce

Arrangements

Joseph Halton, M.D., Sarasota, together with all other railway surgeons in the county who are members in good standing.

HOTEL SARASOTA TERRACE MAY 2, 12:30 P. M.

Round Table Luncheon-Toastmaster, Thomas H. Bates, M.D., Lake City.

2:00 р. м.

Call to Order-Joseph Halton, M.D., Chairman Local Arrangements Committee.

Invocation-Father Charles Eslander, Pastor St. Martha's Church.

Address of Welcome on Behalf of Local Surgeons— Joseph Halton, M.D.

Address of Welcome on Behalf of the City of Sarasota-The Honorable E. A. Smith, Mayor. Response to the Addresses of Welcome—Harold D. Van-

Schaick, M.D., Jacksonville.

President's Address-Thomas H. Bates, M.D., Lake City.

SCIENTIFIC PROGRAM

Address (by invitation)—J. Y. Roberts, M.D., Chief Surgeon, Louisville and Nashville Ry., Louisville, Ky.

"The Golden Decade of Surgery," L. S. Oppenheimer, M.D., Tampa. Discussion: L. M. Anderson, M.D., Lake City;

H. E. Palmer, M.D., Tallahassee. "Fractures of the Pelvis," Frank D. Gray, M.D., Orlando.

Discussion: C. D. Christ, M. D., Orlando; A. R. Beyer, M.D., Tampa.

"Chronic Arthritis," illustrated by lantern slides-Leland F. Carlton, M.D., Tampa. Discussion: A. R. Beyer, M.D., Tampa; Joseph Halton, M.D., Sarasota.

"Are the Railroads Getting a Square Deal?" H. E. Palmer, M.D., Tallahassee.

GENERAL SESSION

Report of Committees. Election of Officers.

PROGRAM

of the

FIFTY-NINTH ANNUAL MEETING of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD AT SARASOTA, FLORIDA

MAY 2nd, 3rd, and 4th, 1932

INFORMATION

Information desk will be located in the lobby of the headquarters hotel, The Sarasota Terrace, with continuous service throughout the meeting. All members will be required to register and secure identification badges before attending any of the sessions. Guests and ladies are requested to register. Tickets for the banquet, Tuesday evening, May 3rd, may be obtained at the registration desk.

ENTERTAINMENT

Trip through John and Mable Ringling Art Museum. Will require 2½-3 hours. Groups will be conducted through and guides provided. Inquire at registration desk for leaving time.

Fishing Trips. Go to Municipal Pier and ask for Ben Seale, who will arrange for your fishing trips. Special rates for guides, boats and fishing tackle from Sunday to Thursday, inclusive.

Swimming. Bring your bathing suits.

Monday, May 2nd

8:30 p.m. Informal Smoker (Stag)-Coliseum.

Tuesday, May 3rd

9:00 a.m. Golf Tournament at Bobby Jones Country Club. Participants wearing identification badges will be admitted without green fee charge.

6:00 p.m. Golf—19th Hole. Entire Association invited. Small green fee charge.

9:00 p.m. Annual Banquet — Mira-Mar Auditorium.

Tickets (\$2.00) may be obtained at registration desk. Entertainment and dance intermittently.

GROUP MEETINGS

Monday, May 2nd

10:00 a.m. Florida Radiological Society—Hotel Sarasota Terrace, Roof Garden.

12:30 p.m. Florida Railway Surgeons — Hotel Sarasota Terrace, Mezzanine Floor.

2:00 p.m Florida Radiological Society—Hotel Sarasota Terrace, Roof Garden.

7:00 p.m. Southeastern Surgical Congress (State Division) Hotel Sarasota Terrace—Assembly Room, Mezzanine Floor.

HOTELS

Hotel Sarasota Terrace, Convention Headquarters — Single, \$2.50; Double, \$4.00.

Sarasota Hotel—Single, \$2.50; Double, \$3.50 to \$5.00. Central Park Manor—Single, \$2.00; Double, \$3.00. Watrous Hotel—Single, \$1.50 to \$2.50; Double, \$2.50 to \$3.50.

Goodrich Hotel—Single, \$1.00; Double, \$1.50. Gulf View Inn—Single, \$1.50; Double, \$1.50.

PROGRAM FOR WOMEN

Monday, May 2nd

7:30 p.m. Theatre party.

Tuesday, May 3rd

9:00 a.m. Registration — Main lobby, Hotel Sarasota Terrace.

11:30 a.m. Cars leave hotel with women of executive board for Gulf View Inn, for luncheon.

1:30 p.m. Cars leave for Gulf View Inn for swimming party.

3:00 p.m. Bridge Tea at Beach Club.

9:00 p.m. Banquet, Entertainment and Ball at Mira-Mar Auditorium.

Wednesday, May 4th

9:30 a.m. Women's Auxiliary Session at Christian Church.

12:30 p.m. Cars leave for Whitfield Country Club for luncheon.

2:00 p.m. Visit to John and Mable Ringling Museum of Art.

Motorcade to St. Armand's Key, Lido Beach.

Evening Entertainment in the nature of a Little Theatre Party by local players planned.

TECHNICAL EXHIBITS

Technical exhibits will be located in booths in the lobby and on the mezzanine floor, Hotel Sarasota Terrace.

The technical exhibits have a real scientific value and physicians who wish to keep abreast of the times and know the latest in drugs and medical appliances should spend some time with these exhibits. It will be surprising the great amount of useful information that can be procured at these exhibits. Many have nothing for sale, the representatives of the firms being there to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to visit the Technical Exhibits.

The following firms have arranged for exhibits at the Sarasota meeting:

American Optical Company. Gerber Products Division. Mead Johnson & Co. Merck & Co. E. R. Squibb & Sons. Surgical Supply Co.

OFFICERS OF SARASOTA COUNTY MEDICAL SOCIETY

JACK HAITON, M.D., President.
O. H. CRIBBINS, M.D., Vice-President.
J. C. PATTERSON, M.D., Secy. Treas.

LOCAL COMMITTEES

Cabinet Committee

JOSEPH HALTON, General Chairman: Jack Halton, President of County Society.
C. B. Wilson, J. E. Harris, F. C. Metzger, David R. Kennedy,
W. J. Johnston, T. W. Taylor

Committee on Exhibits, Registration and Hotels

C. B. Wilson, Chairman; S. G. Hollingsworth, J. C. Patterson

Finance Committee

J. E. HARRIS, Chairman; BLAKE M. LANCASTER, A. O. MORTON

Entertainment and Anglers' Committee

F. C. METZGER, Chairman; T. M. McDuffee, J. F. MASON

Golf Committee-(Courtesy Fees)

DAVID R. KENNEDY, Chairman; L. W. Blake, John R. Scully

Committee on Banquet and Smoker

W. J. Johnston, Chairman; A. Q. English, Jack Halton

Greeters' Committee

	T. W. Taylor, Chairman	1
J. O. Brown	O. H. Cribbins	C. W. LARRABEE
C. H. Bryan	H. Gates	N. P. Myers
G. T. CLARK	M. M. HARR SON	Www. D. Suga

WOMAN'S AUXILIARY

Officers

M C F	D D 11			
MRS. S. L.	. Dr. skell, President			. Jucksonville
Mrs. Leig	н Г. Rotinson, President-el	ect		Ft. Lauderdale
Mrs. W. G	. Post, Jr., Vice-President			St. Petersburg
MRS. E. W	'. Veal, Secretary-Treasurer		 S	outh Jacksonville
MRS. J. N	I. IRWIN, Historian			. St. Augustine
Mrs. Edw.	ARD LELKS. State Editor .			. lacksonville

Local Committee on Arrangements

MRS. W. J. JOHNSTON, Chairman

Mrs. L. W. Blake	MRS. S. G. HOLLINGSWORTH
Mrs. J. O. Brown	Mrs. D. R. Kennedy
Mrs. C. H. Bryan	MRS. B. M. LANCASTER
MRS. G. T. CLARK	Mrs. C. W. Larrabee
Mrs. O. H. Cribbins	MRS. T. M. McDuffee
Mrs. A. Q. English	Mrs. J. F. Mason
Mrs. H. Gates	Mrs. F. C. Metzger
MRS. JACK HALTON	Mrs. A. O. Morton
MRS. JOSEPH HALTON	MRS. J. C. PATTERSON
Mrs. J. E. Harris	MRS. T. W. TAYLOR
MRS. M. M. HARRISON	Mrs. C. B. Wilson

FIRST GENERAL SESSION

Hotel Sarasota Terrace, Roof Garden TUESDAY, MAY 3RD, 9 A. M.

Call to order, Joseph Halton, Chairman of Convention Committee.

Invocation, Father Charles Eslander, Pastor St. Martha's Church.

Introduction of Georgia Delegates.

Announcements.

Address of President, G. H. Edwards, Orlando.

Address (by invitation), "The Present Status of Heart Lesions," Walter Lawrence Bierring, Des Moines, Ia.

SCIENTIFIC ASSEMBLY

Hotel Sarasota Terrace, Roof Garden MAY 3RD, 10:30 A. M.

Committee on Scientific Work: O. O. Feaster, St. Petersburg; N. A. Baltzell, Marianna; C. W. Shackelford, West Palm Beach.

Attention is called to the following By-Laws:

"All papers read before the Society shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orators, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, nor more than once on any one subject."

Drs. Cunningham and Shaw of Jacksonville have furnished their projecting lantern and screen for use at the third Scientific Session, Tuesday evening.

1. "A Proposed Compensation Act and Its Relation to the Physician," Simon E. Driskell, Jacksonville. Type of law. Scope of coverage. Fees permitted, with definite schedule for physicians, hospitals and nurses, Panel of physicians and who shall be called. Report on extent of injury and degree of recovery. Authority vested in Circuit Judge for settlement in case of dispute.

Discussion: F. L. Fort, Jacksonville; Nelson M. Black, Miami.

2. "The Modern Treatment of Thyrotoxicosis," Spen-

"The Modern Treatment of Thyrotoxicosis," Spencer A. Folsom, Orlando.
The pre-modern period. Discovery of exophthalmic goitre. Nature of the thyroid secretion. Further work on toxic goitre. Function of the thyroid. Thyroxin secretion and requirements. Action of thyroxin. Classification of thyroid disorders. The role of basal metabolism determinations. Methods of examination. Diagnosis and differential diagnosis. The clinical course. Etiology. Theories of exophthalmic goitre. Treatment: X-ray therapy. The role of iodine in the treatment of exophthalmic goitre. Surgical treatment. Sequellae. Complications. The medical management.

The medical management. Discussion: T. Z. Cason, Jacksonville;

W. C. Blake, Tampa; C. D. Christ, Orlando.

SECOND GENERAL SESSION

Hotel Sarasota Terrace, Roof Garden

MAY 3RD, 12:15 P. M.

President Edwards in the Chair.

Report of Officers:

Secretary-Treasurer-Editor, Shaler Richardson, and

Business Manager, Stewart Thompson. Executive Committee, Gerry R. Holden.

Public Relations Committee, Henry C. Dozier.

Committee on Legislation and Public Policy, W. M.

Hospital and Medical Education Committee, John E. Boyd.

Council, Samuel Puleston.

Committee on Necrology, Robt. H. McGinnis.

Unfinished Business.

New Business.

SCIENTIFIC ASSEMBLY

Hotel Sarasota Terrace, Roof Garden

May 3RD, 2:00 P. M.

3. "Hay Fever in Florida," Frank C. Metzger, Sarasota.
Present concept of allergic reactions, or shock with particular reference to its action upon the nasal mucosa.
Relatively small amount of work done in Florida in compiling facts concerning air-borne pollens. Report of Relatively small amount of work done in Florida in compiling facts concerning air-borne pollens. Report of pollen counts from various sections of the State and comparison of these results. Allergic rhinitis, annual, its cause and treatment. Florida's value as a hay fever and asthma climate. Methods of finding the offending substances in individual cases. Scratch tests, intradermal, contact tests, etc. Methods and comparative results.

Discussion: E. Sterling Nichol, Miami; B. W. Lowry, Tampa.

"Diabetes in the Home," Roscoe H. Knowlton, St. Petersburg.

Diabetes differentiated from other causes of glycosuria. A brief resume of carbohydrate metabolism with reference to the part played by insulin. The patient should understand his disease. Ways and means by which the process of education may be simplified and carried on in the home. Some suggestions about food intake and the avoidance of complications.

Discussion: T. Z. Cason, Jacksonville; W. C. Blake, Tampa.

"Chronic Infectious Arthritis," Julian E. Gammon, Jacksonville. Etiology and practical methods of treatment.

Discussion: F. L. Fort, Jacksonville; Clayton E. Royce, Jacksonville.

"Amelioration of Labor Pains," Robert G. Nelson, Tampa.

Pain as an important symptom in medicine. Brief review on history of use of drugs to alleviate labor pains: Narcotics. Ether. Chloroform. Twilight sleep. Nitrous oxide. Summary of more recent methods: Oil and ether rectal anesthesia. Spinal and sacral anesthesia. Avertin. Barbaturic acid derivatives. Description of Dial. Its physiological action. Some facts established as to action of Dial after use in one hundred consecutive cases. Description of method and technique of administration. Advantages of use of "Dial" over other methods of alleviating labor pains. Pain as an important symptom in medicine.

Discussion: Samuel R. Norris, Jacksonville; W. M. Rowlett, Tampa.

7. Ophthalmology and Its Relation to General Medicine and Surgery," Nelson M. Black, Miami.

Interrelation between ophthalmology and special sections into which medicine today is divided. Necessity for active cooperation of the ophthalmologist with the internist, pediatrist, otorhinolaryngologist, bacteriologist, pathologist, syphilographer, and dermatologist, roentgenologist, urologist, gynecologist, brain surgeon, oral surgeon, orthopedist and general surgeon. Help one may give the other in determining the etiologic factors in many ocular conditions and arriving at proper diagnosis.

Discussion: Shaler Richardson, Jacksonville; C. E. Dunaway, Miami.

MEETING OF HOUSE OF DELEGATES

Hotel Sarasota Terrace, Roof Garden

MAY 3RD, 5 P. M.

President Edwards in the Chair. Roll Call and Seating of Delegates.

Adoption of Minutes as published in May, 1931, Journal. Election of one delegate and one alternate to A. M. A. mecting (one year term).

Selection of meeting place of Association for 1933.

Reading of resolutions. Unfinished Business.

New Business.

Announcements.

Adjournment.

SCIENTIFIC ASSEMBLY

Hotel Sarasota Terrace, Roof Garden MAY 3RD, 7:30 P. M.

Hygiene of Swimming (with motion pictures), H.

Hygiene of Swimming (with motion pictures), H. Marshall Taylor, Jacksonville.

The healthfulness of swimming as an exercise and recreation is undeniable and this picture is not intended to discourage this sport but to point out that the human body lacks certain adaptations to sojourn in the water and that certain means for its protection are necessary. Man is essentially a terrestrial being, and his anatomy and physiology are not modified for a water environment. When man is out of his normal sphere he must understand what Emitations Nature has placed upon him, and not ignore the fundamental laws that regulate his own being. being

Discussion: Bascom Palmer, Miami; J. W. Taylor, Tampa.

"Roentgenological Examination in the Differential Diagnosis of Abdominal Pathological Conditions," (with lantern slides), Frederick K. Herpel, West Palm Beach.

Discussion of ideal method of procedure leading to a complete X-ray examination of the abdomen, and the desirability of adhering, whenever possible, to a fixed routine. Value of the combined method of examination as contrasted with the roentgenographic method only. Frequency of extra-abdominal pathology as the cause of intra-abdominal pain. Value of a negative roentgenologic examination. Status of the roentgenologist as a consultant. Importance of correlating history, physical examination, laboratary studies and the roentgenologic examination so that maximum value may be given to the patient, maximum service to the attending physician and the value of the consultant he enhanced in proportion to his accumulative experience. his accumulative experience.

Discussion: J. C. Dickinson, Tampa; Harold O. Brown, Clearwater.

"Some Considerations of the Peptic Ulcer Problem" (with lantern slides), J. Knox Simpson, Jacksonville.

> Summary of known factors at work. Most plausible theories which have been brought forward as to instiga-tion of these factors, in the production of chronic peptic ulcer. Evidence upon which a positive diagnosis must stand. Outline of methods which should be used in erad-icating the factors which are at work in the production of an ulcer.

Discussion: John S. Helms, Tampa; Louie Limbaugh, Jacksonville.

SCIENTIFIC ASSEMBLY

llotel Sarasota Terrace, Roof Garden MAY 4TH, 9 A. M.

11. "Diarrheas of Infancy," F. Clifton Moor, Tallahassee.

Statistics showing decrease in infant mortality from diarrhea during past decade and comparison with general mortality. Mention of previous theories as to etiology. Present views concerning etiology based on physiology of normal gastric secretion and the experimental and clinical reaction when such secretion is disturbed. Outline of treatment based on etiological and pathological factors. factors

Discussion: G. S. Osincup, Orlando; Councill C. Rudolph, St. Petersburg.

"Bronchial Asthma," E. Sterling Nichol, Miami. Recent contributions on the etiology, pathology and treatment of bronchial asthma are reviewed and analyzed. Literature on this subject becoming more and more important since the allergic attack offers increasing promise to the victim of asthma. Methods of treatment other than desensitization measures. Importance of careful follow-up study of asthma "relieved" cases over a period of years. Typical case histories.

Discussion: F. C. Metzger, Sarasota; R. L. Cline, Lakeland.

13. "Urinary Obstruction, Recognition of Cause and Its Relief," Gideon Timberlake, St. Petersburg.

Winter resorts, such as afforded by the Florida climate, scem the haven of rest and comfort for males and females. Many of these people, past the three-score years, seem predestined to the hazards of urinary obstructions and acute retentions. In the circumstances, it is the family physician or general practitioner who first sees them and makes for their relief. Acute urinary retentions not exclusively due to prostatic obstruction. While relief is indicated, it does not necessarily follow that radical surgery must be done. Symptoms and diagnosis of acute retention vastly more vivid to patient than to general practitioner or urologist. Pathology and hasic causes for retention seem well afield of patient and general practitioner, and not always clear to urologist.

Discussion: Eugene G. Peek, Ocala; F. H. Langley, St. Petersburg. "Recent Progress in Juvenile Sinusitis," M. A. Lischkoff, Pensacola.

> Modern research has brought out many new facts in the study of juvenile sinusitis. Study of comparative anatomy and development of the sinuses aided by X-ray with omy and development of the studes and the study are a clearer conception of the physiology. Pathological interpretations are more accurate now. Ciliary activity, allergy, diet, local and general immunity, the study of bacterial flora, and its control with vaccines, the effect of cold, the study of the s and ultra-violet, have all enhanced our knowledge of this vast subject.

Discussion: Bascom H. Palmer, Miami; Joseph W. Taylor, Tampa.

15. "The Diagnosis of Chronic Appendicitis," E. W. Bitzer, Tampa.

Analysis of 120 cases in which appendectomies were done for chionic appendicitis. Average time of observation, after operation, was 7.8 years. Number of cases showing complete, partial and no relief. Individual symptoms of these cases analyzed to show what symptoms are most likely to be relieved by appendectomy. Table covering differential diagnosis presented. Short discussion of relief the page appendicities to the ulgar replan. lation of chronic appendicitis to the ulcer problem.

Discussion: John S. Helms, Tampa; J. C. Dickinson, Tampa.

THIRD GENERAL SESSION

Hotel Sarasota Terrace, Roof Garden MAY 4TH, 12 NOON

President Edwards in the Chair.

Unfinished Business.

New Business.

Election of President.

Newly elected President escorted to the Chair.

Election of first vice-president.

Election of second vice-president.

Election of third vice-president.

Election of secretary-treasurer.

Presentation of past-president's button: L. M. Anderson, Lake City.

Adjournment.

SCIENTIFIC ASSEMBLY

Hotel Sarasota Terrace, Roof Garden MAY 4TH, 2 P. M.

16. "Blood Pressure," T. M. Rivers, Kissimmee.

Hypertension and hypotension are discussed in parallel. Hypertension and hypotension are discussed in parallel. Balance of blood pressure is shown to be maintained through the autonomic nerves. Etiologic factors are shown to act through these nerves. These factors are shown to be nerve impulses from the central nervous system. Hormones, amines, creatinine, minerals in the blood, alkaloids and other drugs. Double part played by calcium is shown. Symptoms shown to vary with the action of etiologic factors on other organs. Treatment consists of finding the causes and eliminating them, counteracting the variation of tension, and repairing the damage done to the tissues. damage done to the tissues

Discussion: J. S. McEwan, Orlando; T. H. Bates, Lake City.

17. "The Modern Treatment of Syphilis and Some of Its Complications," Frank Wilson, Jacksonville.

History concerning the four drugs most commonly used in the modern treatment of syphilis, and the manner of their use. Necessity of prolonged treatment even in early cases and the frequent failure of the so-called abortive treatment. Treatment in the different stages. Some of the reactions and complications occasioned by the drugs used in the treatment.

Discussion: Elmo D. French, Miami;

J. L. Kirby-Smith, Jacksonville;

E. T. Sellers, Jacksonville.

SCIENTIFIC ASSEMBLY

13. "Endocervicitis," W. J. Johnston, Sarasota.

Acute endoccrvicitis: etiology and pathology, symptoms Acute endocervicitis; etiology and pathology, symptoms and diagnosis, treatment; use of drugs; mechanical corrections to improve drainage; stressing the advantages of rest. Chronic endocervicitis: etiology and pathology, symptoms and diagnosis. Treatment: emphasizing the dvantages of electro-coagulation by comparison with other modes of treatment.

Discussion: Blake M. Lancaster, Manatee; W. M. Rowlett, Tampa. J. E. Harris, Sarasota.

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FLORIDA MEDICAL ASSOCIATION, INC.

1874-1875-

1876-

1877-

1878-

1879-

1880-

1881-

1882 -1883-

1884---

1885-Dr. Joseph Y. Porter, Key West.*

1886 -1887-

1888-

1889-Dr. R. P. Gary, Ocala.*

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1910-Dr. J. D. Love, Jacksonville.*

1911—Dr. A. H. Freeman, Starke. 1912—Dr. John S. Helms, Tampa. 1913—Dr. P. C. Perry, Jacksonville. 1914—Dr. F. C. Moor, Tallahassee.

1915—Dr. R. H. McGinnis, Jacksonville. 1916—Dr. E. W. Warren, Palatka.

1917—Dr. Ralph N. Greene, Jacksonville. 1918—Dr. F. J. Walters, La Mesa, Cal.

1919-Dr. Wm. E. Ross, Jacksonville.

1920-Dr. W. P. Adamson, Tampa.

1921-Dr. S. R. M. Kennedy, Pensacola.*

1922—Dr. L. M. Anderson, Lake City. 1923—Dr. H. Marshall Taylor, Jacksonville.

1924-Dr. John C. Vinson, Tampa.

1925—Dr. John S. McEwan, Orlando. 1926—Dr. H. Mason Smith, Tampa.

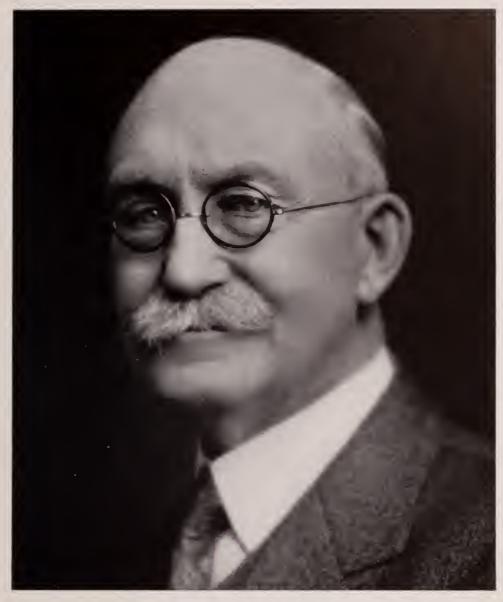
1927-Dr. John A. Simmons, Arcadia.

1928—Dr. F. J. Waas, Jacksonville. 1929—Dr. Henry C. Dozier, Ocala.

1930-Dr. Julius C. Davis, Quincy.

*Deceased.

Note: Please submit information to complete the above list.



DR. WALTER L. BIERRING, OUR HONOR GUEST

T is, indeed, unfortunate that in the arrangement of this earthly sphere, the real workers are often overshadowed by the work and activities they perform. In a measure this is true of our guest this year; for, unless one has followed the progress of medical education and licensure in this country, it is possible that he has escaped notice.

Dr. WALTER L. BIERRING, our honor guest speaker, was born July 15th, 1868, in Davenport, Iowa, where he received his preliminary education. His medical training was received at the University of Iowa and supplemented by studies in Europe. Teaching seemed to be his forte and he returned to his alma mater to teach pathology, as has been the history of many internists. He was Professor of Pathology and Bacteriology at the University of Iowa. Following this he was Professor of the Theory and Practice of Medicine at Iowa and at Drake University. In 1914, he forsook the path of the pedagogue and became interested in medical licensure. He has been president of the Iowa State Board of Health and Medical Examiners; member and president of the National Board of Medical Examiners; secretary-editor Federation of State Medical Boards of U. S.; member of American Commission of Medical Education; member Post-War European Commission of Medical Education. Among other honors, he has been president of the Iowa State Medical Society; president, Alpha Omega Alpha-Honorary Medical Scholarship Society; president, Des Moines Academy of Medicine; chairman, Section Pathology and Physiology, American Medical Association; chairman, Section Practice of Medicine, American Medical Association; member, Board of Regents, American College of Physicians. In 1919 he was made Honorary Member Royal College of Physicians of Edinburgh.

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SARASOTA MEETING

This issue of the Journal is termed the "Sarasota Number." There is an article descriptive of Sarasota, our next meeting place, which the members of the Florida Medical Association will read with interest. Members of the Sarasota County Medical Society are lending every effort to make our meeting a most successful one. The meeting is being held in May in order that those members residing in tourist centers may have a better opportunity of leaving their practice. The Scientific Program Committee states that the program will be a most excellent one, all phases of medicine and surgery being represented.

THE SARASOTA SCIENTIFIC SESSIONS

The committee on Scientific Program has had as its chief aim the collection of papers for the May meeting that will be of interest particularly to that most important group of members, the general practitioner. While several of the essayists are men doing special lines of work, they have been asked to have this in mind when writing. Only those parts of their papers that are of practical interest will be presented on the floor; historical and technical data not of essential interest may be read when the essay is published in the JOURNAL.

A departure from the usual procedure is to be made. The various amenities of the first morning session, which begins at 9:00 a. m. instead of 10:00 a. m., will be dispensed with. Following an invocation and the announcements, will be the President's address and the dissertation of the guest speaker. The regular scientific session will then begin and two papers will be heard the first morning. That afternoon there will be five speakers.

Preceding the banquet there will be a group of three essayists whose presentations will be accompanied by lantern slides and motion pictures. On the morning of the second day, there will be five papers and that afternoon three. The total number of subjects for this meeting has been limited to eighteen so as to allow for more discussion from the floor and to be sure of finishing on time.

Care will be taken to see that neither the essayists nor the discussants exceed their allotted time. Again this year, voice amplifiers will be used so that all may easily hear without undue exertion on the part of the one making the address.

STATE NEWS ITEMS

Dr. J. B. Turner of Bagdad recently announced his candidacy for membership on the local school board. Dr. Turner has been interested in school affairs for many years and has devoted considerable time and effort in the past toward the improvement of public schools in Bagdad.

Dr. H. Mason Smith of Tampa and Dr. Henry Palmer of Tallahassee were in Jacksonville, Wednesday, March 23rd, attending a meeting of the Florida State Board of Health. A new county health unit has been established, under the terms of an act of the 1931 Legislature, in Escambia County. Dr. Wilber A. McFall, formerly health officer for Charlotte, N. C., has been named as health officer for this unit. The Escambia County unit is the third to be established in Florida. It became operative on March 1st.

Dr. J. H. Pittman of West Palm Beach is now located at 401 Guaranty Building. Please note change of address.

Dr. and Mrs. Louie Limbaugh of Jacksonville announce the arrival of a daughter, born March 30th. The girl has been named Louise Carolyn Limbaugh.

The sixth radio broadcast of the State Association over WRUF, Gainesville, was given on March 16th by Dr. M. A. Lischkoff of Pensacola. His subject was "The Medical Profession—Its Value to Society."

Dr. LeRoy Oetjen, formerly of Jacksonville, is now located at Leesburg. His office is located in the Masonic Temple building.

Personnel of the medical and surgical staff of the recently organized Cancer Clinic of Tampa include a number of the foremost surgeons of Tampa.

The board, composed of Dr. Bundy Allen, chairman and president of the clinic; Dr. J. S. Helms and Dr. E. W. Bitzer, appointed the following senior staff members: Dr. Helms, chief of staff and executive officer; Dr. William Rowlett, Dr. Leland F. Carlton, Dr. Herbert R. Mills, Dr. J. C. Dickinson, Dr. Bitzer, Dr. Joseph W. Taylor, Dr. H. J. Blackmon, Drs. Eugene S. Gilmer, C. A. Andrews, H. Mason Smith, F. L. Adamson and Thomas Truelson. The junior staff membership is not yet complete.

Dr. James B. Parramore of Jacksonville has moved his offices from 401 to 435 St. James Building.

Dr. D. C. Main of Pomona has announced himself as candidate for the office of superintendent of schools, Putnam County.

CONVENTION NOTES

The Atlantic Coast Line Railroad has named a very low round-trip fare from Jacksonville to Sarasota and return, tickets on sale May 1 and 2, good for returning until May 5. Through the efforts of the Atlantic Coast Line officials, similar very low round trip fares will be on sale in other cities in Florida. Other railroads have been approached and it is understood that similar rates will be available on practically all railroads from any part of Florida to Sarasota, applicable to our convention dates. Those who anticipate going to Sarasota by rail should see their local railroad agent, who will have official schedules in connection with the special rates available.

Drs. L. W. Cunningham and W. M. Shaw of Jacksonville have furnished their projecting lantern and screen for use at the third scientific session, Tuesday evening, May 3rd.



Bring your bathing suits. The water's fine.

The State Division of the Southeastern Surgical Congress will meet at 7:00 p. m. Monday, May 2nd, in the Assembly room on the mezzanine floor of the Hotel Sarasota Terrace.

The following has been received from Dr. W. J. Johnston, chairman of the Committee on Banquet and Smoker:

The smoker scheduled for Monday night, May 2nd, will be a memorable landmark in the annals of the State Association. This will be a real night of entertainment. Two good wrestling bouts are on the program, one of which will be between two of the best heavyweights available in the south; the other, a middle-weight affair,

will bring together two of the cleverest boys that have been seen in action in Florida this winter.

Other added attractions will be a battle royal, staged by several of the dark-town strutters and three other bouts of boxing, two eight-round and a ten-round wind-up, for which the best boys in the state, available at that time, have been secured. And now you're only half way in.

A novelty surprise contest among members of the Association has been arranged but it's a dark secret. The Committee on this night of hilarious fun insists on every member being present on Monday night. You really can't afford to miss it!

It has been said that there will be much to stimulate the imagination so necessary to the full enjoyment of the occasion.

It's a fair bet that this event will take supersedence over all former events, casting them into oblivion and marking a new era from which you will date everything.

No language is strong enough to express the desire of the Committee in urging you to be present for this is sure to be a night that will long live in your memory.

The Florida Radiological Society will hold two sessions on Monday, May 2nd, at the Sarasota Terrace Hotel. The first will be at 10:00 a.m., and the second at 2:00 p.m.

A trip to and through the John and Mable Ringling Art Museum has been arranged and proper guides secured. The hours have not been set, but will be arranged so as not to conflict with any of the scientific sessions. Information can be secured at the registration desk regarding the time of departure. The trip will consume from two and one-half to three hours.

The Florida Railway Surgeons' Association will meet Monday, May 2nd, at the Hotel Sarasota Terrace. There will be a round table luncheon at 12:30 p.m., with Dr. Thos. H. Bates of Lake City as toastmaster. The general meeting, followed by the scientific session, has been called for 2:00 p.m.

The golf course at the Bobby Jones Country Club, where the annual tournament will be held, is in exceptionally good shape. Participants wearing their identification badges will be admitted without green-fee charges. All doctors are asked to compete in the tournament. The whole Association is invited to play the 19th hole at 6:00 p.m. on Tuesday. There will be a small greenfee charge to play that hole, but it will no doubt be very interesting.

A treat is in store for all who wish to fish. A guide, Ben Seale, has been secured. He will be at the Yacht Club on the Municipal pier from Sunday through Wednesday and will arrange for fishing parties—any kind of fishing. He will see that equipment is furnished. It is suggested that devotees of Isaac Walton come down for Sunday fishing or stay after the close of the convention,



"King of the Deep"

and spend Thursday at this sport. It is possible that tarpon-fishing will be good at the time of the meeting. Trout and king-fish can be depended upon.

Buy your banquet tickets as early as possible, at the registration desk. This will give those in charge of the banquet an indication of the number of guests for which to prepare.

COMPONENT COUNTY SOCIETIES LAKE COUNTY MEDICAL SOCIETY

THE LAKE COUNTY MEDICAL SOCIETY HAS AGAIN ATTAINED THE DISTINCTION OF HAVING A 100% SOCIETY. THE ROSTER OF THIS SOCIETY WAS RECENTLY RECEIVED, ACCOMPANIED BY 100% OF THE 1932 DUES OF ITS MEMBERS. C. M. TYRE OF EUSTIS IS PRESIDENT, A. L. IZLAR OF CLERMONT, VICE-PRESIDENT; AND W. L. ASHTON OF UMATILLA IS SECRETARY.

MANATEE COUNTY MEDICAL SOCIETY

MANATEE COUNTY MEDICAL SOCIETY IS AGAIN 100% PAID. DUES FOR 1932 FOR ALL MEMBERS OF THIS SOCIETY HAVE BEEN RECEIVED AT THE OFFICE OF THE STATE ASSOCIATION.

ST. JOHNS COUNTY MEDICAL SOCIETY

THE ST. JOHNS COUNTY MEDICAL SOCIETY HAS PAID ITS TOTAL ASSESSMENT FOR 1932. THIS IS ONE OF THE SOCIETIES WHICH CAN BE DEPENDED UPON TO REPORT 100% OF ITS DUES BEFORE THE TIME OF THE ANNUAL MEETING EACH YEAR.

SARASOTA COUNTY MEDICAL SOCIETY

THE ENTERTAINING SOCIETY OF THE NEXT CONVENTION OF THE ASSOCIATION IS ON THE HONOR ROLL. ALL 1932 DUES FOR THE SARASOTA COUNTY MEDICAL SOCIETY HAVE BEEN RECEIVED AND THIS SOCIETY IS ONCE MORE IN THE 100% PAID GROUP.

SUMTER COUNTY MEDICAL SOCIETY

THE SUMTER COUNTY MEDICAL SO-CIETY HAS PAID ITS TOTAL ASSESS-MENT FOR 1932 AND HAS BEEN PLACED ON THE HONOR ROLL WITH THE OTHER SOCIETIES WHICH ARE 100% PAID. DR. W. E. MITCHELL OF COLEMAN IS AGAIN SERVING AS SEC-RETARY OF THE SOCIETY.

TAYLOR COUNTY MEDICAL SOCIETY

The following officers were recently elected by the Taylor County Medical Society, to serve for the ensuing year:

President—J. C. Ellis, Perry.

Sec'y-Treasurer—Jas. L. Weeks, Perry.

Dr. Ralph J. Greene will represent this Society, as delegate, at the annual meeting in Sarasota.

THE TAYLOR COUNTY MEDICAL SO-CIETY HAS AGAIN "GONE OVER THE TOP". THE 1932 ROSTER OF THIS SO-CIETY AND 100% OF DUES WERE RE-CENTLY RECEIVED FROM DR. JAMES L. WEEKS OF PERRY, THE TREASURER OF THE SOCIETY.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, INC.

State Editor

Mrs. Edward Jelks,

2244 St. Johns Avenue

Jacksonville

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ON TO SARASOTA!

We regret that space will not permit us to give the program of the forthcoming Convention of the Auxiliary to the A. M. A., which meets in New Orleans, May 9-13. However, we feel that the Florida Auxiliary is most fortunate because we are to have Mrs. Walter Jackson Freeman (president-elect of the A. M. A. Auxiliary) with us at our State meeting in Sarasota, May 2, 3, 4, at which time, we hope, she will tell us about the plans of the New Orleans Convention.

If anyone is able to attend both of these conventions, she is to be congratulated; but please make every effort to go to Sarasota to our own state meeting. First, because it is our state meeting and, second, because you cannot afford to miss either Mrs. Freeman or the Art Museum!

SARASOTA'S GREETING TO DOCTORS' WIVES

The following greeting comes from Mrs. W. J. Johnston, Chairman of the Women's Committee:

"Sarasota eagerly awaits the opportunity of entertaining the State Medical Convention, the first week in May.

"The ladies have been joyously preparing a program for the entertainment of the doctors' wives on this occasion and only regret that the short time allotted will not allow us to do all that we would wish to do.

"We are very proud that we are to be honored, at this time, by the presence of Mrs. Walter Jackson Freeman, president-elect of our American Medical Association Auxiliary. All of the doctors' wives of Sarasota and Manatee counties join me in welcoming Mrs. Freeman, Mrs. S. E. Driskell, our state president, and her official family, and all the ladies who will visit Sarasota during the convention."

Pre-Convention Greeting Mrs. S. E. Driskell, State President

When you read the program of delightful entertainment arranged by the hostess ladies I know you will immediately plan to be in Sarasota at the time of the state meeting, if possible.

You will notice that the morning of May 4th is given to the meeting of the State Auxiliary. Whether you are an auxiliary member or not, you are urged to attend this one general session which will open promptly at 9:30.

Rev. W. A. Harp, pastor of the Christian Church, will give the invocation. Mrs. W. J. Johnston will make the address of welcome, to which Mrs. Wilburn Lassiter of Gainesville will respond.

There will be brief reports by all the officers and chairmen, and by the presidents of all the County Auxiliaries.

Delegates and alternates will be elected to represent our state at the meeting of the Woman's Auxiliary to the American Medical Association to be he'd in New Orleans May 9-12.

Officers will be elected to serve during the coming year. Mrs. M. A. Lischkoff, Pensacola, Chairman; Mrs. L. F. Robinson, Fort Lauderdale, and Mrs. J. E. Taylor, DeLand, have been appointed a nominating committee to present to the convention names of women who are eligible for election.

But the greatest treat of all, and one you cannot afford to miss, will be an address by our National president-elect, Mrs. Walter Jackson Freeman of Philadelphia, who is to be our guest of honor at the meeting.

We hope there will be a splendid representation present from every section of the state, that we will all enjoy the fellowship and the inspiration of the meeting and that we may be able to turn over to the new administration a wellrounded organization ready to meet the greater opportunities that are before us.

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SARASOTA, FLA.

Here is a letter from Mr. Will Beale, noted writer and author of "Frontier of the Deep", who was a recent guest of the HOTEL CENTRAL PARK MANOR, who writes the following letter to the Sarasota Chamber of Commerce:

Chamber of Commerce, Sarasota, Florida.

Gentlemen: Your office gave me, amongst others, the name of the CENTRAL PARK MANOR HOTEL. We selected the CENTRAL PARK MANOR HOTEL.

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ALACHUA COUNTY

The following report of Alachua comes from Mrs. Wilburn Lassiter:

The annual election of officers was held at our regular monthly luncheon, on Thursday, March the tenth. The following were elected:

President—Mrs. T. Byron King, Gainesville. President-Elect—Mrs. D. T. Smith, Gainesville. Vice-Pres.—Mrs. J. E. Maines, Jr., Gainesville. Secretary—Mrs. E. H. Andrews, Gainesville. Treasurer—Mrs. W. C. Thomas, Gainesville.

BROWARD COUNTY

A most enthusiastic and excellent report was received from Mrs. R. H. Stovall of the Broward County Auxiliary. This Auxiliary has put Hygeia magazine in all the County Schools and public libraries, made donations of clothing and school supplies to persons in want, and, last fall, the Auxiliary entertained the County Medical Society, with a barbecue supper at the beach. This supper was such a success that the men are asking for another, and this is now being planned for a date in April.

CENTRAL FLORIDA SOCIETY

Mrs. S. E. Driskell was our guest on February 25th, at the semi-annual dinner of the Central Florida Medical Society, which was held at the Hotel Thomas, in Gainesville. We were delighted to have our president with us and thoroughly enjoyed the message she brought in her talk, following the dinner. She brought to our group the possibilities of work as outlined in our Constitution and By-Laws. I wish that every auxiliary in the state might have the privilege of having our president with them. To know her brings a realization of a splendid executive.

DUVAL COUNTY

The Woman's Auxiliary to the Duval County Medical Society met in the assembly room of the Hotel Mayflower, on March the tenth. Mrs. E. W. Veal, president, presided and Mrs. Neil Alford acted as secretary.

After a routine business session, during which some special philanthropic work was planned, Mrs. J. L. Chilli made a talk on the value of Hygeia and plans were made to increase the sale and use of this health magazine.

Mrs. S. E. Driskell told the story of Jane Todd Crawford upon whom the first ovariotomy was performed.

MARION COUNTY

The following report is from Mrs. W. B. Jordan, of Marion County:

The regular meeting of the Auxiliary to the

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FUL-VUE BIFOCALS AMERICAN OPTICAL COMPANY

Marion County Medical Society was held at Paradise Lodge, Silver Springs, on January the thirty-first. The election of officers for the ensuing year was as follows:

President—Mrs. J. N. Moore. Vice-President—Mrs. T. H. Wallis. Sec'y-Treasurer—Mrs. W. B. Jordan. Social Chairman—Mrs. T. H. Wallis. Hygeia Chairman—Mrs. E. G. Linder.

ADVERTISERS' NOTES

Dr. G. H. A. Clowes, Director of the Lilly Research Laboratories, Receives Doctor of Science Degree From Butler University

The recent installation of a new president of Butler University, Indianapolis, was made the occasion of conferring doctorage degrees upon several men who have distinguished themselves in science, letters, and public service. Among those so honored was Dr. George H. A. Clowes, Director of the Lilly Research Laboratories, who received the degree of Doctor of Science.

Dr. Clowes, a native of England, received his early scientific training at the Royal College of Science, London. Later he attended the University of Goettingen, where he received the degree, Doctor of Philosophy.

Dr. Clowes came to the United States in 1900. For about eighteen years he served as research chemist of the New York State Cancer Laboratory. During the World War he was connected with the United States Chemical Warfare Service. At the close of the war he joined the research department of Eli Lilly and Company, Indianapolis, and took out citizenship papers. Since 1920 he has been Director of Research of the Lilly Laboratories.

Dr. Clowes is a member of leading scientific societies of America and Europe. He is the author of numerous papers dealing with important problems in chemistry, biology, pharmacology, and pathology. During the summer seasons for many years he has been engaged in studying fundamental chemical and physiological processes of the cell at the Marine Biological Laboratories at Woods Hole, Massachusetts. To the scientific world he is known especially for his studies of protoplasm and the intimate relation between the living and non-living systems. In his capacity as Director of the Lilly Research Laboratories he co-operated with a number of university groups of investigators in the development of important medical discoveries which have been made available for use in the treatment of disease.



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In November, 1921, the S.M.A. Corporation announced an epochal development in The Journal of the American Medical Association.

This development was called S.M.A. and resembled breast milk so closely that about 95% of infants deprived of breast milk would do well on it. It was a departure particularly in its preparation of the fats, and it also was a departure because it included enough cod liver oil to be antirachitic.

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More than 3 hundred million feedings of S.M.A. have been prescribed by physicians.

A TRIAL SUPPLY of S.M.A. with complete feeding suggestions will be sent to physicians upon request. Infant Record Sheets and weight charts will be included if you say so.

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S.M.A. is a food for infants—derived from tuberculin tested cows' milk, the fat of which is replaced by animal and vegetable fats including biologically tested cod liver oil; with the addition of milk sugar, potassium chloride

and salts; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties.

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Professors Drummond and Hilditch have recently confirmed that for high vitamins A and D potency, Newfoundland cod liver oil is markedly superior to Norwegian, Scottish and Icelandic oils.

They have also shown that vitamin A suffers considerable deterioration when stored in white glass bottles.

For years, Mead's Cod Liver Oil has been made from Newfoundland oil. For years, it has been stored in brown bottles and light-proof cartons.

Mead's 10 D Cod Liver Oil also enjoys these advantages, plus the additional value of fortification with Mead's Viosterol to a 10 D potency. This ideal agent gives your patients both vitamins A and D without dosage directions to interfere with your personal instructions. For samples write Mead Johnson & Company, Evansville, Ind., U. S. A. Pioneers in Vitamin Research.

S.M.A. PRODUCTS APPROVED

Word has just been received that the Committee on Foods of the American Medical Association has approved SMACO (400) Maltose and Dextrins.

This makes twelve products of the S.M.A. Corporation that have successfully met the requirements and have been approved by this committee, which is well known to have very high standards. It speaks well for the skill and high standards of this company that so many products have thus far been approved.

First on the list of approved products of this company, of course, is S.M.A., both powder and concentrated liquid forms, the only antirachitic breast milk adaptation. Other products of S.M.A. Corporation approved are SMACO (204) Concentrated Liquid Half Skimmed Milk, SMACO (207) Powdered Half Skimmed Milk, SMACO (300) Hypo-Allergic Whole Milk Sterilized Liquid, SMACO (303) Hypo-Allergic Skim Milk Sterilized Liquid, SMACO (200) Whole Cow's Milk, Sterilized Liquid, SMACO (203) Concentrated Liquid Whole Milk, Sterilized, SMACO (205) Concentrated Liquid Skim Milk, Sterilized, SMACO (206) Powdered Whole Milk, SMACO (208) Powdered Skim Milk.

The Council on Pharmacy of the American Medical Association has also re-accepted Protein S.M.A. (Acidulated) following the annual re-examination of products they accept.

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THE NEXT MEETING
OF THE
FLORIDA MEDICAL
ASSOCIATION
WILL BE HELD AT
SARASOTA
MAY 2-3-4, 1932

SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

SOCIETY Alachua J. E. Maines, Jr., M. Gainesville. D. M. Adams, M.I. Panama City. I. K. Hicks, M.D. Melbourne. Broward Broward Columbla Columbla Columbla T. H. Bates, M.D. Lake City. Robert T. Spicer, M. Miami. DeSoto-Hardee-Highlands F. L. Fort, M.D., Jacksonville. J. M. Hoffman, M.I. Pensacola. J. R. Bruce, M.D. Jasper. J. T. Cowart, M.D. Tampa. T. H. Hudgens, M.I. Sneads. W. L. Ashton, M.I. Umatilla. Lee H. Quillian Jones, M. Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Madison Manatee Manatee Manatee Manatee Marion Orange O. G. Kendrick, M. Tallahassee. Marion A. Q. English, M.I. Manatee. W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Manatee. Palm Beach Polk Merman Watson, M. J. W. Palm Beach. Palm Beach Polk Polk Herman Watson, M. L. Merman Watson, M. L. W. Warren, M. L. Merman Watson, M. L. Merman Watson, M. L. Merman Watson, M. L. W. Warren, M. L. Merman Watson, M. L. W. Warren, M. L.	2nd Tuesday 2nd Tuesday 3rd Tuesday 3rd Tuesday 4. Last Wednesday. 1st Monday 1st Friday 4. Last Tuesday 5. Last Tuesday 6. Last Tuesday 7. Last Tuesday 8. Last Tuesday 9. Last Tuesday 9. Last Tuesday 1st Tuesday 9. Last Tuesday 1st Tuesday 1st Thursday	3 *	White House Varies Elks' Hall Blanche Hotel Club Room Huntington Bldg. Varies Mayflower Hotel Board of Health Building Tampa Municipal Hospital Marianna Eustis Lee Memorial Hospital Varies	Ves. No. Occasionally. Yes. No. No. No. Yes. No. Yes.	Paid.
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Highlands Sebring. Duval F. L. Fort, M.D., Jacksonville. J. M. Hoffman, M.I Pensacola. J. R. Bruce, M.D. Jasper. J. T. Cowart, M.D. Tampa. T. H. Hudgens, M.I Sneads. W. L. Ashton, M.I Umatilla. H. Quillian Jones, M.Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Geo. O. Davis, M.I Madison. Madison Geo. O. Davis, M.I Madison. Marion Geo. W. R. Warren, M.I Key West. J. R. Chappell, M.I Orlando. Palm Beach V. M. Johnson, M.I W. Palm Beach. Pasco-Hernando-Citrus Geo. R. Creekmore, M. Brooksville. Alvin L. Mills, M.J. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M. I. Lec. M.D. Jasper. J. R. Creekmore, M. Brooksville. Alvin L. Mills, M.J. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M. I.	lst Tuesday 2nd Tuesday 1st Tuesday 2nd Tuesday 2nd Tuesday 2nd Tuesday 1st Thursday 1.D., 3rd Friday D., Quarterly D., lst and 3rd Tuesda Oct. to May: 2n Tues., May to Oct.	8:15 P.M. 8:00 P.M. 3:00 P.M. 12:30 P.M. 7:30 P.M.	Mayflower Hotel Board of Health Building Tampa Municipal Hospital Marianna Eustis Lee Memorial Hospital Varies	No. No. No. Yes.	
Duval	1st Tuesday 2nd Tuesday 1st Tuesday 2nd Tuesday 2nd Tuesday 2nd Tuesday 3nd Tuesday 4nd 4nd 5nd 6nd 6nd 6nd 6nd 6nd 7nd 7nd 7	8:00 P.M. 8:00 P.M. 3:00 P.M. 12:30 P.M. 7:30 P.M.	Board of Health Building Tampa Municipal Hospital Marianna Eustis Lee Memorial Hospital Varies	No. No. Yes.	
Escambla Pensacola. J. R. Bruce, M.D. Jasper. J. T. Cowart, M.D. Tampa. Jackson T. H. Hudgens, M.I. Sneads. W. L. Ashton, M.I. Umatilla. H. Quillian Jones, M. Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Geo. O. Davis, M.I. Madison. Manatee W. B. Jordan, M.I. Manatee. Marion W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Key West. J. R. Chappell, M.J. Orlando. V. M. Johnson, M.I. W. Palm Beach. Pasco-Hernando-Citrus Geo. R. Creekmore, M. Brooksville. Polk Merman Watson, M. Lakeland. E. W. Warren, M. Lakeland. E. W. Warren, M. Lakeland.	2nd Tuesday 1st Tuesday 2nd Tuesday 2nd Tuesday 2nd Tuesday 3nd Friday 4nd Friday 4nd Friday 5nd Friday 5nd Friday 6nd Friday 6nd Friday 7nd Friday	8:00 P.M. 3:00 P.M. 12:30 P.M. 7:30 P.M.	Building Tampa Municipal Hospital Marianna Eustis Lee Memorial Hospital Varies	No. No. Yes.	
Hamilton Jasper. J. T. Cowart, M.D. Tampa. T. H. Hudgens, M.I. Sneads. W. L. Ashton, M.I. Umatilla. Lee H. Quillian Jones, M. Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Geo. O. Davis, M.I. Madison. Madison Geo. O. Davis, M.I. Manatee W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Key West. J. R. Chappell, M.I. Orlando. Palm Beach V. M. Johnson, M.I. W. Palm Beach. Pasco-Hernando-Citrus Geo. R. Creekmore, M. Brooksville. Alvin L. Mills, M. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M. L.	1st Tuesday D., 2nd Tuesday D., 1st Thursday 1.D., 3rd Friday D., Quarterly D., 1st and 3rd Tuesda Oct. to May: 2nd Tuesday D., Tuesday	3:00 P.M. 12:30 P.M. 7:30 P.M. 3:00 P.M.	Hospital Marianna Eustis Lee Memorial Hospital Varies	No. Yes. No.	
Hillsboro Tampa. Jackson T. H. Hudgens, M.I. Sneads. W. L. Ashton, M.I. Umatilla. H. Quillian Jones, M.Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Geo. O. Davis, M.I. Madison. Madison Geo. O. Davis, M.I. Madison. A. Q. English, M.I. Manatee. W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Key West. J. R. Chappell, M.I. Orlando. Palm Beach V. M. Johnson, M.I. W. Palm Beach. Pasco-Hernando-Citrus Geo. R. Creekmore, M. Brooksville. Alvin L. Mills, M. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M. Lakeland.	1st Tuesday 2nd Tuesday 2nd Tuesday 1st Thursday 1st Thursday 2nd Friday 2nd Tuesday 1st Thursday 1st and 3rd Tuesday 2nd Tuesday 2nd Friday	3:00 P.M. 12:30 P.M. 7:30 P.M. 3:00 P.M.	Hospital Marianna Eustis Lee Memorial Hospital Varies	No. Yes. No.	
Jackson Sneads. W. L. Ashton, M.I. Umatilla. H. Quillian Jones, M.Ft. Myers. Leon-Gadsden-Liberty-Wakulla-Jefferson Geo. O. Davis, M.I. Madison. Madison Geo. O. Davis, M.I. Madison. A. Q. English, M.I. Manatee. W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Key West. J. R. Chappell, M.J. Orlando. V. M. Johnson, M.J. W. Palm Beach. Pasco-Hernando-Citrus Geo. R. Creekmore, M. Brooksville. Alvin L. Mills, M.J. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M.I. E. W. Warren, M.I. E. W. Warren, M.I.	2nd Tuesday 1st Thursday 1.D., 3rd Friday D., Quarterly D., 1st and 3rd Tuesda Oct. to May: 2n Tues., May to Oct.	3:00 P.M. 12:30 P.M. 7:30 P.M. 3:00 P.M.	Eustis Lee Memorial Hospital Varies	Yes.	
Lake	1st Thursday 1.D., 3rd Friday D., Quarterly D., 1st and 3rd Tucsda Oct. to May: 2n Tues., May to Oct.	12:30 P.M. 7:30 P.M. 3:00 P.M.	Lee Memorial Hospital	No.	
Lee	D., Quarterly D., lst and 3rd Tuesda Oct. to May; 2nd Tues., May to Oct., May to Oct.	7:30 P.M. 3:00 P.M.	Hospital Varies		
Liberty- Wakulla- Jefferson	D., lst and 3rd Tucsda Oct. to May; 2nd Tues., May to Oct.	3:00 P.M.	-	Yes.	
Madison. Madison. A. Q. English, M.I. Manatee. W. B. Jordan, M.I. Ocala. W. R. Warren, M.I. Key West. J. R. Chappell, M.I. Orlando. V. M. Johnson, M.I. W. Palm Beach. Pasco-Hernando-Citrus. Pinellas. Pinellas. Polk. Herman Watson, M. Lakeland. E. W. Warren, M.I.	O., lst and 3rd Tucsda Oct. to May; 2nd Tues May to Oct.	78,			
Manatee	Oct. to May; 2nd Tues., May to Oct.	78,			
Marion Ocala. Monroe			Dixie Grande Hotel	Yes.	
Monroe		12:30 P.M.	Marion Hotel	Yes.	
Orlando. Palm Beach	D., 1st Sunday	9:00 P.M.	Varies	Yes.	
Palm Beach Pasco-Hernando-Citrus Geo. R. Creekmore, Merooksville. Alvin L. Mills, M. St. Petersburg Herman Watson, M. Lakeland. E. W. Warren, M.	D., 3rd Wednesday	8:30 P.M.	Varies	No.	
Citrus Brooksville. Alvin L. Mills, M. St. Petersburg Polk Herman Watson, M Lakeland. E. W. Warren, M.		8:00 P.M.	Good Samaritan Hospital	No.	
Polk	M.D., 2nd Thursday	7:00 P.M.	Varies	Yes.	
Polk Lakeland. E. W. Warren, M.	D., Every other Thurs		Assembly Room, 5th floor, P. & L. Bldg.	No.	
E. W. Warren, M.	2nd Wednesday in Feb., Apr., June Aug., Oct., Dec.		Lakeland	Yes.	
Putnam Palatka.		7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns Reddin Britt, M.D St. Augustine.		8:30 P.M.	Varies	Yes.	
St. Lucie-Okeecho- bee-Indian River-Martin J. D. Parker, M.D. Stuart.		8:00 P.M.	Varies	Yes.	
J. C. Patterson, M.I. Sarasota.		8:30 P.M.	Varies	Occasionally.	
J. T. Denton, M.D. Sanford.		8:00 P.M.	City Hospital		
Sumter W. E. Mitchell, M.I. Coleman.			Varies	No.	
Jas. L. Weeks, M.I.	Zilu Tuesuay	8.00 T/ M			
Joseph H. Rutter, M Volusia Daytona Beach.		- 8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Walton- A. G. Williams, M.	Last Friday	7 -20 D M	Varies	Yes.	
Okaloosa Lakewood. Washington-Holmes	.D., 2nd Tuesday	7:30 P.M. 8:00 P.M.	Varies	Occasionally.	



A Garden at the Home of Mrs. Potter Palmer

The following song may have played a large part in the carrying of the 1932 Association meeting to Sarasota. It was written and sung to the tune of "Mandalay" by Dr. Jack Halton at the last Convention. Dr. Halton makes no apologies to Kipling:

On the Bay at Sarasota,
Near the Gulf of Mexico,
You will find the things that please you
And we want you all to go
Where the wind is in the palm trees
And the tarpon's in the Bay.
That's the place for you in '32,
Oh, you must not say us nay,
No, you cannot stay away!

Sarasota on the Bay
Is a dandy place to play;
You can see the tarpon leaping
From Rangoon to Mandalay.
Sarasota on the Bay,
Where in '32 we'll play,
There will be no sleep on the briny deep
And you'll hate to go away!

THE JOURNAL

OF THE

Florida Medical Association, Inc.

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VOLUME XVIII NO. 11

President's Address

Proceedings of the Fifty-Ninth Annual Meeting of

Jacksonville, Florida, May, 1932 THE N Yearly Subscription, \$3.00

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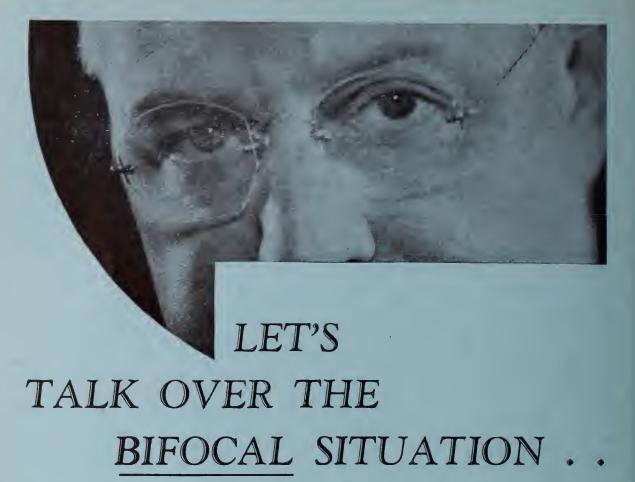
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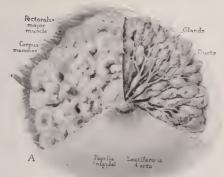
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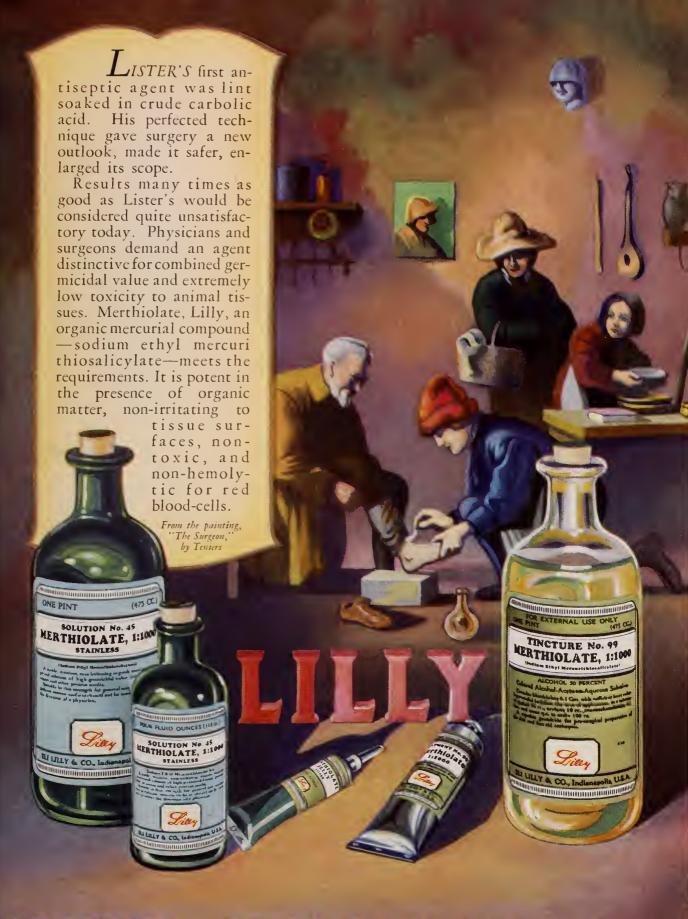
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XVIII

Jacksonville, Florida, May, 1932

Number 11

President's Address*

G. H. Edwards, M.D., Orlando.

The twelve months which have elapsed since you honored me with this office have passed with seeming unwonted rapidity. As I glance backward, I note many things which I had in mind to do but which I have not consummated. I had hoped to visit more societies, become better acquainted with you, as individuals, and more conversant with the problems which our group, as physicians, are heir to. Although I have driven over 5,500 miles, attending committee meetings, visiting county and district society meetings, I feel that the contemplated tasks were but begun.

It is, indeed, undeniably a great privilege, though one filled with responsibility, to occupy this chair, but it is also, I believe, a great privilege to be admitted to membership in this Association, to gain which, one has had to study faithfully the basic principles of life, of the healing art, of motives, of reactions of all kinds, in order to favorably complete tests which will reveal one's competency to practice. And the responsibilities which we accept with our admission, are equally trying and will take much fortitude and much intelligence and possibly much intuition to successfully discharge.

To insure our success as physicians, both individually and as a group, there are several factors which play a part in determining whether we fail or succeed. We are constantly meeting all sorts of patients, with varying degrees of intelligence and with almost as many outlooks on life as they are in number. So the physician to be most efficient should be able to meet, on their own ground, patients with all types and stages of mental development. This means adaptability and of no mean order, for to be acceptable in this way will require a wide range of information. Not only in medicine itself does the physician need extreme technical knowledge, but he should

*Delivered before the Fifty-Ninth Annual Meeting of the Florida Medical Association, held at Sarasota, May 3, 4, 1932. be informed on all the better things encompassed in a general education. This will require much outside reading and study, but it will keep him out of a rut, will command respect and will be to himself a source of much pleasure and relaxation. Some patients may demand in us only a knowledge of medicine, yet their confidence in our ability will be increased by the extent of our knowledge in matters not entirely germane to it.

Due, first, to the varying individuality, the results of diet, of climatic rearing, of previous diseases, etc.; second, to the varying virulence of the same germ, and third, to the varying reaction of the individuals to the same germs and to the same drugs or methods of treatment, the practice of medicine becomes to a certain extent an experiment. The different reactions, which are produced in different individuals by the same disease demand careful weighing, a study of each case, and should lead to a careful tabulation of the results of the treatments instituted, thus making of a physician an investigator. It is by such careful, critical study that light is thrown from different angles on diseased conditions. This enables us to formulate new or re-adjust our present therapeutic measures. The practice of medicine has developed in the past by this method and will continue to do so. Many conditions that now are only ameliorated will be cured and others now considered hopeless will be brought under some degree of control. Some remedies we now have will be discarded, others will have their efficiency increased and still many remedies now unknown await the results of trial and some will be found serviceable and potent; but only if the physician looks at each case by itself and keeps a constant eve and mind upon the results of medication.

Medical science is not like modern industrial methods where innumerable articles are turned out daily, identically alike. Medicine is not me-

chanical as expressed today in the forming and later the assembling of parts. It is a study, a personal study, of abnormal conditions in a being, with all his individual and often peculiar personality and his ancestral background, in varying surroundings and under varying conditions of mental and physical tension. We may make complete physical and X-ray examination, investigate the blood and all secretions, make a record of changes from day to day and yet, when it comes to the advice given with the medicine prescribed, there must be for the best results, a careful evaluation of all the factors entering into this individual's makeup; that is, we must give a personal service to each patient. We are then assuming, as we should, a personal responsibility. We must get away from the shot-gun formula, from the thought that if a certain drug helps one person, it must be good for all. The viewpoint of the public health officer and his mass production, as expressed in preventive medicine is wonderful and efficient, yet it aids us but little here. We must remember that on our personal encouragement and advice and on our human understanding and willingness to explain to the individual, depends often the patient's health and his future happiness.

In giving this personal service one need not, indeed, should not, always depend upon his own observation and beliefs. The field of medicine is large and ever extending-I might say, too large for any one man to perfectly encompass so the intelligent physician will seek assistance from a colleague interested in some special branch of medicine, not so much to divide responsibility-which is often advisable-but so as to be in a position to give better advice; and advice need not be and often is not in the line of medical service alone. It may be social, economic, educational and religious, depending upon which factor or force is clouding the mind, depressing the spirit or somehow registering its effects upon the lives of our patients. The more we know of these factors and their effects upon men's minds and lives, the more intelligently can we trace their course and the more wisely can we give counsel. We, as physicians, need the intuition of woman, the sagacity of a Solomon and steadfastness of purpose.

At the Pensacola meeting in 1930, your Executive Committee was instructed to investigate the possibilities of obtaining a master insurance policy, defending all members of the Florida

Medical Association, who so desired, in suits for malpractice. The ensuing year the committee held many meetings with insurance agents and corresponded extensively with a number of insurance companies in an effort to obtain the most favorable policy for our members. A report was made to you at the Convention held in Orlando in 1931, showing that a master policy had been obtained and that at that date 315 individuals had taken out protection under it. At this time I again bring it to your attention for the reason that damage suits have increased rapidly in number and in the amounts demanded, apparently on account of hard times, many people thinking they can replenish their somewhat depleted coffers by suing their physicians. For this reason I feel it advisable that all of us who are in a branch of medicine in which the line of treatment and the results obtained are open to criticism, should be protected by insurance. The saving to the physician carrying an average amount of insurance, under this, our State policy, is nearly enough to pay his yearly dues to the State Association, while to the physician in a line especially open to suit, as a surgeon or roentgenologist, where the amount of insurance carried is often large, the saving might be many times more than the dues. This is one more reason for an individual keeping up his membership in this Association and thus enjoying the benefits of the lesser premium open to our members.

Our policy has been examined by attorneys in two cities, who are authorities on insurance matters, and they pronounce it to be the best obtainable, an excellent one, covering all features necessary to our protection. The company itself—the United States Fidelity and Guaranty—in which our policy rests is one of the largest and strongest in the country.

The sad commentary is that quite recently a number of our members have purchased malpractice insurance from a high-powered salesman who represents a company with a surplus of \$300.00 and which is not licensed to do business in the State of Florida. Your Association conducts a well-manned business office, from which, by phone or letter, reliable information can be furnished promptly. Why stumble into pitfalls when we can help you to avoid them?

In some sections and in the minds of some individual members there seems to be a feeling that our dues are too high and that there is extravagance in the administration of our affairs.

The small sum which we contribute yearly to the Association might well be considered as a premium on a form of insurance, which will to some extent protect us against influences and encroachments which are destructive to ourselves, our ideals, our very existence. Were it not for the influence of this Association and some of its members in the past, we, today would face a much more serious state of affairs. Had certain proposed legislation been enacted, the practice of medicine and Board of Health activities would be in a sad state. There is, I feel, a distinct honor in being a member of this Association. It gives to us a very creditable professional position and a public influence which otherwise would be lacking and which costs little more than the price of four eigarettes each day, or for some other luxury.

The joint report of the secretary, treasurer and business manager will show that there has been no extravagance and no mismanagement. Our surplus fund has been safely and wisely invested and while the amount on hand may seem large, our increasingly larger position in public affairs and our campaign of education demands that the fund be increased continuously. In 1927, 1928 and 1929 with a membership of approximately 1,100, we were able to get out of debt and build up a surplus of some \$10,000; but now, with a decrease in membership from removals and death and with comparatively few additions, our expenses in proportion have crawled up. The past year our surplus has increased about \$1,700, due entirely to the activity of our business manager, in decreasing salaries and curtailing expenses, especially in connection with the publication of the Journal. But it will decrease rapidly if the Public Relations and Legislative Committees continue to display the activity they now present.

If our dues are reduced to \$5.00, as suggested by a few, our present surplus would eventually become exhausted and our Association would become little more than a skeleton organization. The Journal would have to be curtailed, until it might revert to the type and irregularity of the early twenties. The activities of the Public Relations Committee would have to be entirely discontinued and it is more than probable that we would lose the services of our very efficient business manager.

I believe that if any change is made our dues should be materially increased so that a medical defense fund could be established, which would

enable us, first, to engage or retain the very best legal talent available, to advise us regarding needed legislation, how to obtain it and to act in the Halls of Legislation with us; second, to give advice and possibly aid to the Board of Medical Examiners in prosecution of those, who by false testimony and evasion may become, illegally, practitioners; third, to assist the County Societies both with legal advice and money when necessary, as you will find recommended in the report of the Executive Committee. The state is overrun with irregular and unlicensed practitioners, who prey upon the skeptical and ignorant valetudinarian. There seems to be little or no effort at present being made toward doing anything to enforce existing laws pertaining to the practice of medicine. In fact, it often seems as if the regular constituted legal authorities of the state are looking for some excuse to avoid prosecution instead of trying to enforce the law. With the County Society initiating a movement to rid the state of these undesirables, knowing it will be backed legally and financially by the State Association, I believe marked headway can be made. If it be generally known that we are actively going to protect our own interests and the welfare of our public, fewer questionable healers will open offices among us. Fourth, this would assist in the protection of any of our members unjustly accused in any matter relating to the legitimate practice of medicine. There is more than an economic loss to the member, who is the victim of legal threats. A verdict against anyone in the Florida Medical Association reacts to the disadvantage of the whole medical profession, so the indirect influence against us, if conviction ensues, is many times greater than the direct benefit to the one protected, when he is cleared of the charges. I have a feeling that as long as an individual is a member in good standing, we should protect him to the fullest extent possible and I might almost add no matter how heinous the crime. The County Society through its Board of Censors should be able to certify for membership only those who will be a credit to this Association or at least will make honorable conscientious members. If, perchance, someone does get in who later fails in his professional behavior, the Society, on advice of its censors, can remove his name from the roster and I trust this will be done when needed, but as long as he is a member in good standing, we should and most support him in all attacks upon his professional skill and reputation.

to present and dissertate upon obscure and rare lesions and symptoms, because a fellow specialist is on the receiving end and can take part in the discussion. But, in the scientific sessions of our Association, the general practitioner is in the majority and all papers should be so prepared that he may benefit. It is the general practitioner who is the real foundation of medical practice, not the specialist. He is the one who sees the patient first, who must be qualified to recognize the meaning of early symptoms, slight and indefinite as they may be. He is the individual who must make the early diagnosis and in a manner sort out the cases, one to this specialist, a second to another and many he takes care of himself with or without assistance or consultation. His is, at times, a difficult task requiring a keen insight into human nature; for many a patient seems to feel that a physician can and should by intuition know what is at fault even when the said patient endeavors at times to deliberately lead one astray. We, to be successful, should and must be able to suspect and, long before a condition can be proven, take proper precautions and measures and give the right advice early, when it will do the most good. No matter how clever the surgeon or the alienist, he is helpless when the malignancy has developed beyond operative removal or when the brain cells have become so diseased that medicine and removal of irritants, internal or external, cannot obliterate the lesion by this time definitely established. Each case has to be and should be definitely classified early to obtain the best results from treatment and this is the task facing the majority of us here, the general practitioner. You will further note that in arranging our program this year, by having only five papers presented in a session more time is available for those who wish to enter into the discussion. Each one of us can the better comprehend a paper by the perusal of it in the quiet of our

You will note in the scientific sessions this year

that all papers presented are written so as to be

of interest to the general practitioner. In meet-

ings of specialists, it is proper for the essayists

study, but then the subject matter is viewed from one angle only, while in the discussion following the verbal presentation many angles and sidelights are often uncovered, making the paper the more valuable to the person interested in that particular subject.

For several years there has at times been

voiced the question: "Why not have a presidentelect for the Florida Medical Association?"

This past summer this undercurrent of thought seemed to break through the crust of conservatism and routine and many asked the same question: "Why not have a President-elect?" You may recall the correspondence in our Journal this past year regarding it. Personally, I feel the addition of that officer to the official family of the Association would be an excellent act. There is no question but what in the past many of our presiding officers have been elected and inducted into office with almost no idea of the responsibilities and duties which would be demanded of them and it has taken many months before they became acquainted with the set-up and routine. Save for a most efficient business manager, secretary and executive committee my term of office this year might have been disastrous. A year's acquaintance with the routine of the office, sitting as an ex-officio member of all committees, cannot but give an individual an insight which will make him not only conversant with the affairs but by that same sign make him a much better executive and leader. To create this office it will be necessary to amend the Constitution. I quote Article X: "The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Meeting, provided that such amendments shall have been presented in open session at the previous Annual Meeting, and that it shall have been sent officially to each component County Society at least two months before the meeting at which final action is to be taken."

This present Constitution and By-Laws were presented and discussed at the meeting in Orlando in 1923 and adopted at the meeting in 1924 in St. Petersburg. From many quarters I have heard the thought voiced that this instrument of ours is obsolete and hoary with age and not at all suited to present-day medical trends of thought. In a way I doubt this in its entirety. It is not old, only eight years. Many of you here today played a part in drafting it and in compiling its provisions. It is elastic enough to cover all medical matters and under it, this organization has flourished and developed in a most auspicious manner. But, I must admit that in considering some of its provisions, either we failed in properly coordinating some of the articles in the Constitution and corresponding ones in the By-Laws or else there was some carelessness displayed in editing them. Probably both factors played their part.

Since there seemed to be a general desire to have a President-elect, which would necessitate an amendment to the Constitution, and due to the above mentioned conflicts between Constitution and By-Laws, following correspondence with some of the older members of this Association, I appointed a committee consisting of three former Presidents to carefully go over this instrument, eliminating conflicts, clearing up ambiguities, considering the numerous suggestions for change and where deemed advisable, preparing amendments, thus making our guide, if possible, more elastic, vet easier of interpretation. A preliminary report of the committee was made at the pre-convention meeting held in Orlando in February and many valuable suggestions were made, which the committee has embodied in its report to be given to you shortly.

There seems to be a thought in the minds of many, probably of a majority of the medical profession, that some sort of publicity should be offered, so that our public may understand the nature of and some of the purposes and steps in the effort made by scientific medicine to prevent, control and cure disease. I feel that it is as much a duty to guide and direct the individual along the pathway of health, as it is to care for and cure him when he has made a mis-step and is ill. Many of us feel that in addition to individual advice, education by publicity is necessary in order to get more easily the cooperation and confidence that is needed to make our efforts as physicians a complete success. But there is a wide divergence of opinion as to the character of the publicity and the methods and means of its distribution. I do not speak of the confidence which our patients have in us individually and which is necessary for our success, but I refer to the confidence in scientific medicine as a whole, a problem in which the whole profession is concerned and in which we must take a more or less active part. This confidence will be more positively established when our public knows the many sources of our knowledge and the methods by which it is acquired. This may, indeed, be quite difficult to obtain, for even in the minds of many of us as physicians it is hard to see long-cherished theories discarded, because they seem to conflict with scientific facts, even after we know in detail all the steps by which the facts were reached. It would be absurd for us to try to instruct our patients that they might diagnose and treat their own ills. But I feel that a public properly educated and gently guided will continue to look to us for protection.

That this Association, therefore, might play its part in the education of our public, at the meeting held in 1930 in Pensacola, your Executive Committee was instructed to institute a program for medical education of the laity. This act and its later development was the direct result of the most illuminating and instructive address of the then president, Dr. H. C. Dozier of Ocala. The Executive Committee could add to itself as many members of the Association as it saw fit, in order to carry on the work. It selected five individuals who were to constitute an auxiliary committee, whose duty was to prepare plans for the education of the general public in the value of scientific medicine and in the promotion of public health.

The plans of procedure as worked out were presented at the 1931 meeting in Orlando and they met with your approval. At the first meeting the past year, your committees of both Executive and Public Relations, as the latter is now termed, felt that in order to make better contacts, it should be enlarged to ten members, which was done, and the plans as outlined were put into operation. The progress made will be reported to you at the second general session.

I feel that the committee is still too small and that there should be a member on this committee, if not from every Society, at least from each councilor district, or an active individual in each district, conversant with the committee's aims, who would act as an official contact man.

In the same connection, I would call attention to the fact that you have under the Constitution a group of members known as Councilors, whose duties are (I quote from Section 2 and 3, Chapter VII, of your By-Laws)—"to be organizers, peacemakers and censors for their district. They shall visit each county in their district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. They shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association and all questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to them without discussion." Under the present Constitution

these individuals are supposed to be elected, but as a matter of fact have been appointed since 1924, when the late hour and the few members present occasioned a motion suspending the usual method of procedure and instructing the president to appoint the necessary number of councilors. I believe this to be the proper method of procedure, as it has resulted in the appointment of individuals well known in their section of the state, because of their interest and zeal in organized medicine, whereas, by election, any individual happening to be present at an annual meeting might be and in the past has been elected, even though possessing no qualifications whatsoever for the office. I trust that in the revised By-Laws it will read "The Councilors shall be appointed by the president" instead of elected as at present.

Now it would seem to me that this group of members, selected because of their fitness and because of their wide distribution in the state might well be or should be the contacts between the Committee on Public Relations and the County Society and the public in their districts. The members of the County Society should be in close touch with the efforts being put forth to educate their public, their patients. With these councilors as official contacts, either the original committee of five members, as selected in 1930, or the present committee of ten should be sufficient; they, the fountain of activity, while the councilors would be the streams through which the information would be distributed. With this added duty the council would approach still nearer its proper place in the structure of our organization, that is, next to the Executive the most important committee group.

As many of you know, your Public Relations Committee wrote, compiled, and adapted a number of papers on public health, preventive medicine, etc., subjects of interest to every family, and these papers were released weekly at some labor and expense to the Association. turned out, however, the demand for these articles was not as general as we had hoped, so these releases were discontinued until the time arrives when there is on the part of the daily press a greater desire for our information. A few newspapers gladly accepted and published our material. Many more were not interested and some were distinctly hostile, apparently misunderstanding our aims and viewing us either from a commercial standpoint or as a group who were attempting to acquire publicity without paying for the space. It is my thought that the Councilors could and should be our points of contact in their own districts between the press and our Association, explaining our aims, which are wholly philanthropic and interesting the editors in the articles which we have to offer for the public weal.

The better educated our public is, the more sure they are to demand, or at least desire, a well-behaved physician. The patient or seeker after health does not care for an intimate knowledge of our disagreements with, or our dislikes for, some of our associates in medicine. Every practitioner has a following who feels that he is the one that he can truet, and rightfully so, because he has quietly guided some relative or friend through an illness where the result for many days may have been in doubt. A blighting remark regarding the man or his methods may be quite like a boomerang and injure not so much the one for whom it was intended but the medical profession as a whole, as it would show that we were not a united family in our effort to educate and heal. This raising a question in our patient's mind, as to methods employed might result in a loss of faith and consequently a slower recovery, since we know that confidence is a great factor in the improvement of many of our sick ones. The making of extravagant claims for our own work and ideas and the disparagement of other earnest workers puzzles the public and, I feel, therefore harms both the individual physician and the profession as a whole and lessens the value of our educational efforts.

There is today a continual encroachment on the legitimate work and duties which lead to a livelihood for the practitioner of medicine. In the past, we have had the origin and development of schisms of many kinds, all bearing a title which labels them as practitioners of some type of the healing art, often tied up to a religious formula. In my day I have seen many such cults arise, some have faded, others are still ascendant, some have a truth somewhere in or near the cornerstone, others have no scientific base whatsoever. Although the disciples of them still lead some of our public astray for a time, the majority of them return to us when a distinct emergency arises. For these wanderers we can have only sympathy in their misfortune and do our best to alleviate their suffering. We must continue or increase our efforts to so educate our patients by public utterances and personal

explanations that fewer will be charmed by the siren's song.

There are two other encroachments on our professional life, one partially from within. Today, there is a rapidly increasing number of clinics, so called, being established in communities all over our state. Their inception was most worthy and philanthropic, that is, to give medical advice and aid to individuals, who through misfortune could not afford to meet a physician's charges, modest though they might be, those of the proud type, who would not incur a debt unless something was in sight whereby it might soon be discharged-a most desirable type of citizenship and one for which all of us, as physicians, have great sympathy. Also there are those who are indifferent to their own ills and to those of their children or dependents. An awakening of these to their duties and an assistance for a time in the new path is certainly commendable.

Now I would not be understood as being opposed to these charitable activities, as such, but the scope of these clinics has broadened until we find individuals, well able to pay, attending them looking for free advice. I have in mind pre-school clinics, baby feeding clinics, underprivileged children clinics, dietetic clinics and clinics devoted to an assault upon the denisens of our intestinal tract. Most of these are clinics manned by men from within our own ranks, capable, in good standing, yet knocking out from under our and also their own practice-save as the advertising factor might tend to bring them new patients-a portion of the foundation upon which ability to practice medicine without financial worry is based. The individual without worries is able to the better study his cases and thus give better service, than the one whose unoccupied moments are filled with apprehension instead of study or rest.

It is difficult for me to suggest a good remedy for this clinic encroachment upon the revenue of the general practitioner. I feel that our own members who man these clinics should refuse to consider individuals who have a family physician, unless indigent and referred to the clinic by him, and those who can afford to pay something toward medical care. Patients coming to a free clinic should be only those who are referred to it through the County or City Departments of Charity, or some welfare group and to accept others it seems to me is a clear violation of medical ethics. It is possible that members

of the Women's Auxiliary, who are often also members in the civic, Parent-Teachers' Association or educational clubs, who foster and promote these clinics and dispensaries, might well endeavor to check the mad rush of the said clubs toward a place in the sun. Whereas, the activating thought of aiding the unfortunate one is most Christlike and beautiful, the abuse of the charitable factor in their makeup is in many places becoming disastrous to the general practitioner. And further, in the discussion within the club or sponsoring organization there is always brought forward the reason that the prospective patients are those who cannot get proper and skillful medical attention, losing sight of the fact that the physician is always the greatest contributor to charity in his community. He listens and advises the indigent not only during office hours but in the dead of night; not only on days when to be out and abroad is a pleasure. but also in storm and tempest, when by being out, his health and often his very life is endangered.

The second encroachment is that presented by the activity of our own government in opening Army and Navy hospitals and clinics, not only to congressmen and their families and bureau employees but also many times to friends and political supporters. In addition, the United States Veterans' Bureau is planning a hospital expansion up to 150,000 beds which will not only care for all those who have service injuries and illness but also will admit all veterans, even with conditions non-service in origin, it matters not their nature; it seems to me almost an encouragement of carelessness and indifference to health. And this program is planned despite the presence today of more than 200,000 beds in civilian hospitals which can be utilized and where the veterans would get as good or even better attention and at no greater cost than in a government institution, without the enormous overhead cost of construction and later of maintenance, to the government. These civilian hospitals are being used today for the women who saw service, our maternal government allowing a nominal sum for their care. Why not open them also to men in the same manner?

Last June, in Philadelphia, the House of Delegates of the American Medical Association passed a resolution of which I quote a portion:

"Resolved, That the House of Delegates of the American Medical Association petition the Congress of the United States and the American Legion to abandon the policy of rendering hospital and medical benefits to veterans of the World War with non-service connected disability, and substitute therefor a plan of disability insurance benefits with the following provisions:

"First, the creation of a Bureau of Disability Insurance in the Veterans' Bureau as now constituted.

"Second, the issuance of a disability insurance policy to each veteran with a disability benefit clause, as follows:

- (a) The payment of a weekly cash benefit during a period of total disability, and
- (b) The payment of liberal hospital benefit sufficient to cover the hospital expenses of a veteran during a period of hospitalization for any disability. Such benefits to be paid to a veteran on satisfactory proof of total disability, and
- (c) Such other provisions as are necessary for the proper administration of the act."

I may state that I have canvassed our County Societies the past month regarding your reaction to the above resolution. All communications received were unanimously in favor of the recommendation therein expressed and I have so informed our congressmen asking them to support it when the time comes. I feel that it would be appropriate for our House of Delegates to approve this resolution of the American Medical Association and so inform our congressmen. If

we do not make some effort to prevent further encroachment by our government in its medical activities, we will either be government employees or else out of a job. Frankly, I see no reason, if veterans can be hospitalized for a non-service condition, why all citizens, and especially taxpayers, should not have the same privilege.

There are a number of other subjects; namely, state medicine legislative activities, group practice, compulsary health insurance, County Society Health Clinics, which are bound to have a great influence upon the future of the practice of medicine and upon which I should like to express my views, but today time forbids. I will say this only, that we must be awake to these changes and encroachments and temper them to some extent, if possible, to our advantage or at least try to protect ourselves from complete subjugation.

My term of office is rapidly drawing to a close. The many things I had hoped to do, but in which I have failed, appall me. I may state, however, that it has been a source of great pleasure to me to work with and for you and that your friendship has been an inspiration to me. I want to take this opportunity of expressing to you my appreciation of the distinct honor you conferred upon me and I wish to thank you one and all for the cooperation you have accorded me, and for your patience with me, when I may have stumbled in some of my official acts.

PROCEEDINGS

of the

FIFTY-NINTH ANNUAL MEETING
of the

FLORIDA MEDICAL ASSOCIATION, Inc. HELD AT SARASOTA, FLORIDA MAY 3rd, and 4th, 1932

The Fifty-ninth Annual Meeting of the Florida Medical Association was called to order at 9:00 a. m. on the Roof Garden of the Hotel Sarasota Terrace at Sarasota by Dr. Joseph Halton, Chairman of the Convention Committee. The invocation was rendered by the Reverend J. D. Hurt, pastor, First Methodist Church, Sarasota. Dr. G. H. Edwards of Orlando then delivered the annual presidential address.

Dr. Walter Lawrence Bierring of Des Moines, Ia., having been invited as the guest of honor, delivered an address on "The Present Status of Heart Lesions."

Dr. Edwards introduced Mrs. Walter Jackson Freeman, of the Woman's Auxiliary to the American Medical Association, who spoke a few words relative to the efforts of the Woman's Auxiliary to cooperate with the medical profession in the medical education of the public. Mrs. Freeman also expressed the heartfelt greetings of her father, Dr. W. W. Keen, who is now 95 years of age, and had asked to be remembered to his former pupils, patients and friends.

Dr. John S. Helms of Tampa introduced Dr. Charles W. Roberts of Atlanta, Ga., and asked that the privileges of the floor be extended to

Dr. Roberts. Dr. Roberts made a brief address on behalf of the Georgia Medical Association, and extended an invitation from that organization to attend their annual meeting in Savannah.

This concluded the first general session of the meeting.

SCIENTIFIC ASSEMBLY

At 10:30 a. m., May 3rd, the Scientific Assembly convened, with Dr. O. O. Feaster, chairman of the Scientific Program Committee, in

The following scientific papers were then read and discussed:

the chair.

"A Proposed Compensation Act and Its Relation to the Physician," Simon E. Driskell, Jacksonville.

"The Modern Treatment of Thyrotoxicosis," Spencer A. Folsom, Orlando.

SECOND GENERAL SESSION

The Second General Session convened on the Roof Garden of the Hotel Sarasota Terrace at 12:15 p. m., May 3rd, and was called to order by the president, Dr. G. H. Edwards.

The following joint report of the Secretary and Business manager was read by Dr. Shaler Richardson:

JOINT REPORT OF
SECRETARY-TREASURER, EDITOR OF
THE JOURNAL, DR. SHALER RICHARDSON, AND BUSINESS MANAGER, DR. STEWART G.
THOMPSON

To the President and Members of the Florida Medical Association in Session at Sarasota: Gentlemen:

MEMBERSHIP

During the calendar year 1931, the various component societies of the state forwarded dues for 934 members as compared with a total of 964 for the previous year, which represents a shrinkage in our paid membership of 30. This is less than one member for each society. Under prevailing economic conditions, we feel that this is a very creditable showing and indicates a thriftiness, enthusiasm and interest in the activities of the various societies comprising component units of the State Association.

A number of members left the state and 74 were dropped by county societies for failure to pay 1931 dues. This, however, is a much better showing than for the previous year as in 1931 there were 83 members automatically dropped for not having paid 1930 dues. It would appear, therefore, that the low point in our membership

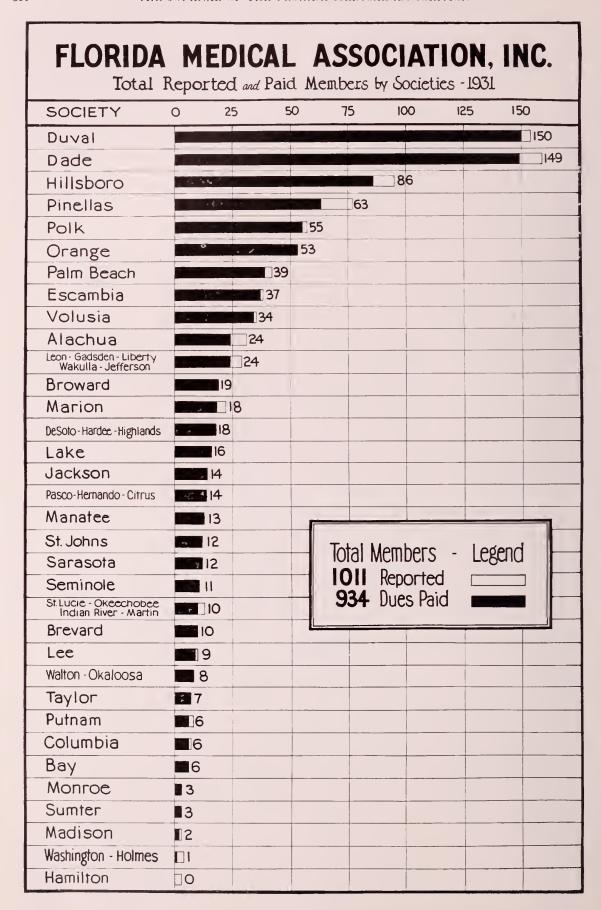
has been reached and the future should show the beginning of an increase in the number of members shown as active on our roster.

The societies showing increases in paid memberships for the calendar year 1931 are as follows: Bay, Dade, DeSoto-Hardee-Highlands, Duval, Jackson, Lake, Manatee, Orange, Pasco-Hernando-Citrus, Sarasota, and Taylor. The societies having the same number of paid members for 1931 as for the previous year are: Brevard, Broward, Madison, Monroe, Polk, St. Johns, Seminole and Sumter. The societies having 100% of members paid for the year 1931 are: Bay, Brevard, Broward, DeSoto-Hardee-Highlands, Jackson, Lake, Manatee, Monroe, Orange, Pasco-Hernando-Citrus, St. Johns, Sarasota, Seminole, Sumter, Taylor and Walton-Okaloosa. The membership records of the component societies just reviewed show 11 societies increasing their membership, 8 societies maintaining an equal membership as for the previous year, and 16 societies having 100% of state dues for their members paid. This is a splendid record and speaks for itself as to the strength of our membership as reported by the various component societies.

IMPOSTORS

In our report last year, we called attention to two impostors who were operating among our members. During the past year, two more were reported. As soon as information regarding these impostors was received, circular letters, containing all available data were dispatched to the president and secretary of each component society in the state. Several of our members loaned money to the first impostor before his identity was discovered. This case was of an individual who impersonated Dr. James M. Acker of Aberdeen, Mississippi. He assumed the name of a good doctor whose credentials or identification papers be secured. These were sufficient to mislead almost anyone who did not know Dr. Acker, himself. This same impostor also asserted himself to be one of our own members. Since this particular member was above reproach but not known to the doctor contacted, the impostor gained sufficient confidence to have checks cashed and to borrow money.

The second case was of a man giving his name as Ted Beall (alias D. A. McCord, alias J. A. Malone), and his buddy, E. J. Wilcox, representing the Physicians' Health and Accident Company of Dallas, Texas. They worked in Jacksonville, Ocala, Orlando, St. Augustine and



West Palm Beach recently and sold numerous policies. A telegram from the American Medical Association stated that this company had a surplus \$367.17 on September 30, 1931. A telegram from the State Treasurer at Tallahassee advised that the Physicians' Health and Accident Company of Texas is not authorized in Florida. A radio announcement stated that warrants had been issued in several cities for the apprehension of these representatives.

We would like to take this occasion to warn the membership of our Association against these various impostors who come into our midst with "hard luck" stories, asking to cash checks, and who are always in a hurry. Credentials are apparently not sufficient as most of these individuals forge checks or give identification credentials of sufficient weight to mislead the average individual. All members are urged to call up their county society secretary for information regarding strangers before cashing checks, lending money, making purchases or endorsing new activities. Your secretary either has the necessary information or will secure it promptly through our office.

OFFICE ACTIVITIES

One of the most important items in connection with our office this past year was the complete separation of all our activities from the office and office employees of the State Board of Health with the exception of the Business Manager. An office was rented by our Association in the Florida Theatre Building for practically half price, i. e., \$15.00 per month. A whole-time stenographer-bookkeeper was employed and from the management of the building, desks and chairs were purchased on a re-claimed basis at the low sum of \$39.00. The balance of our office equipment was quite complete as filing stacks, supply cabinet, etc., have been accumulated from time to time during the past six years.

The office is well organized and efficiently operated for the convenience of all members of the Association. Letters are typed for your officers, copies of all rosters typed and mailed to the various secretaries of component societies and minutes kept for practically all committees. The office work has steadily increased. Daily correspondence in connection with articles for the Journal, advertisements, exhibits, and miscellaneous inquiries demand a large portion of each day's time. Each original article is mailed out and returned to the office twice before it is ready for publication since there are two members on

the Publication Committee beside the editor. The editing and proof-reading in connection with the make-up of the Journal is also responsible for a large portion of the time of each day. The bookkeeping, typing of letters, mimeographing, and mailing of the Journal is a regular routine.

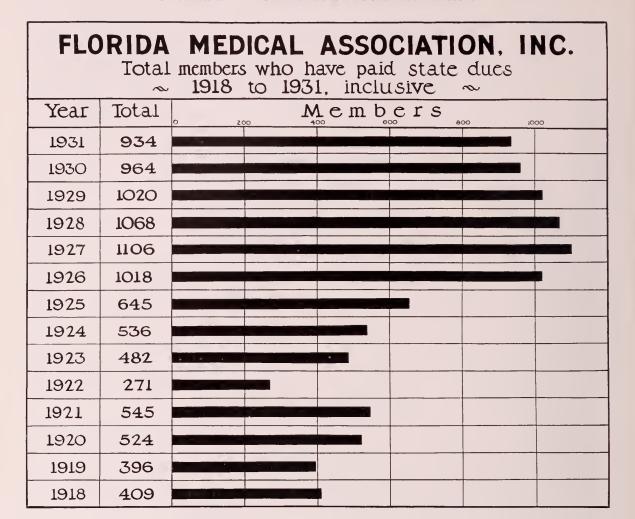
JOURNAL

Many of the authors of original articles during the past year have illustrated their articles and thus not only made them of much more interest but also made the Journal more attractive. The Association's action in paying part of the expenses of making cuts for illustrations has in a measure been responsible in encouraging authors to take advantage of the use of diagrams and pictures in the publication of their articles. There is a continuous flow of articles into the editor's office and, in fact, for several years, there has never been a shortage of material for the scientific part of the Journal. All articles received, which have met with the approval of the Committee on Publication, have found a place in the pages of the Journal.

Dr. Roy Holmes of Miami and Dr. H. L. Bryans of Pensacola should receive a vote of thanks and special mention for their untiring efforts and helpfulness in the prompt return of the articles they have reviewed during the past year. The work of reviewing and editing the original articles is tedious and requires a great deal of time. The two members of this Committee just mentioned have made a real contribution to the Journal in their untiring efforts in this particular line of the Association's work.

The advertising, while somewhat less than for the previous year, has held its own remarkably well with regard to income. For the most part, the regular advertisers have kept their places in the advertising pages of the Journal and have, through this medium, made a real contribution to the revenue of the past year.

The price of printing the Journal was gone over with the officers of the printing company with the result that a 10% discount on all prices for printing has been allowed, which will mean a saving of approximately \$360.00 per year in the printing of the Journal. The prices for reprints have also been reduced and a new schedule of prices made available free of charge, by the printer. This will mean a saving to the authors who contribute original articles for the Journal if they desire reprints after the articles are published.



FINANCES

The operating expenses of the Association's business during the past year were kept within the budget approved by your Executive Committee. The business affairs of the Association and the activities of the business office have been carried on in the usual manner. Expenditures have been very conservative and purchases made only after taking bids in order to obtain the very lowest figure possible. Paper, envelopes and supplies were secured at wholesale prices. The Association's funds, which have been saved by careful attention in this respect, amounts to quite a considerable sum.

The financial condition of your Association is portrayed in detail by the attached statements which have been prepared from the official books and audited by a firm of certified public accountants. Receipts during the year totalled \$13,568.08, as shown by the consolidated cash statement. This revenue was received from dues collected, earnings from advertising, subscriptions to the Journal, interest, and earnings from

technical exhibits. Under disbursements are shown General Fund expense, Journal expense, Technical Exhibit expense, Legislative expense, Furniture and Fixtures, and Library, amounting to \$11,816.38. There is, therefore, a net surplus of \$1,751.70 for the past fiscal year. There is a total cash balance on hand now of \$11,100.44 as compared with a total of \$9,348.74 last year. In addition to the cash balance, the Association has resources in the form of government bonds, of \$10,000.00.

FORD, BOYD & COLLEY
CERTIFIED PUBLIC ACCOUNTANTS

JACKSONVILLE, FLA.,

April 25, 1932.

Dr. SHALER RICHARDSON, Treasurer, Florida Medical Association, Jacksonville, Florida.

DEAR SIR: This is to certify that we have examined the attached statement of Cash Receipts and Cash Disbursements for the period from April 21, 1931, through April 15, 1932. These statements have been prepared by Dr. S. G. Thompson, Business Manager of the Florida Medical Association, and the Florida Medical Journal and correctly reflect the total amounts received and disbursed as shown by the books.

In accordance with your instructions, we have checked the total of the collections shown by the statements with the corresponding total shown by the books, and found them to be in agreement.

Cancelled checks were examined and compared with the entries in the Cash Disbursement Book; the Cash Book was added and all postings checked to the General Ledger; and the General Ledger was added and a Trial Balance taken off as of April 15, 1932.

Bank accounts were reconciled with the bank state-

As we do not have access to the records of the various County Societies for the purpose of checking the remittances for dues, attention is directed to Exhibits D and F which show the amounts received from each County Society during the year and dues cancelled, respectively. The inspection of these Exhibits by the officers of the respective Societies will enable them to verify the correctness of the remittances and cancellations shown.

Income from Journal advertising was verified substantially by an examination of the contracts with advertisers. On March 26, 1931, the Association issued its check for

\$10,188.44 in payment of

FBC:W

Ten (10) U. S. Treasury Bonds, par value of \$1,000.00 each. Interest Rate 3 3/8%. Coupons due March 15, 1932, have been clipped.

The bonds have been inspected by us.

In conclusion, we are again glad to state that the books and records of the Association have been well and neatly kept.

Yours very truly, FORD, BOYD & COLLEY, By F. B. Colley.

CONSOLIDATED CASH STATEMENT April 21, 1931, through April 15, 1932.

Receipts

Cash in Bank, April 21, 1931	\$	9,348.74
Dues Collected (Exhibit "D") \$	9,460.00	
Earnings from Advertising		
(Exhibit "E")	2,912.13	
Subscription and Miscellaneous		
Sale of Journal	11.40	
Bonus from Cooperative Medical		
Adv. Bureau	262.70	
Interest on Savings Accounts and		
Investment	511.85	
Earnings-Technical Exhibits (Ex-		
hibit "C")	410.00— \$	13.568.08
	-	
Total Cash to be Accounted for	\$.	22,916.82

Disbursements

General Fund Expenses	
(Exhibit "A")\$	3,957.30
Journal Expenses (Exhibit "B")	7,148.39
Technical Exhibit Expenses	
(Exhibit "C")\$145.44	
To Entertaining Society 246.00	391.44
Legislative Committee Expenses	207 20
Furniture and Fixtures	99.00
Library	13.05— 11.816.38
Balance in Bank, April 15, 1932	\$11,100.44

EXHIBIT "A"

CASH STATEMENT—GENERAL FUND April 21, 1931, through April 15, 1932

Receipts

Cash as per last audit	\$13,495.65
Back Dues Collected	
(Exhibit"D")\$ 3,140.00	
Current Dues Collected	
(Exhibit "D") 6,320.00	9,460.00
Interest on Savings	511.85
Total Cash to be Accounted for	\$23 167 50

Disbursements		
Postage and Supplies\$ 283.39		
Telephone and Telegraph 166.78		
Salaries 2,518.52		
Secretary-Treasurer		
Salary 583.33		
Convention Expense 141.72		
Auditing Expense 12.50		
Bond of Treasurer 26.25		
Office Rent 97.50		
Traveling Expense 120.23		
	3,957.30	
Legislative Committee		
Expense	207.20	
Furniture and Fixtures	99.00	
Library	13.05	
To Journal Fund (\$3.00 per mem-		
ber paid, 1929, 1930, 1931 and		
1932 collections)	2,838.00—	7,114.55
Cash Balance		\$16,352.95

EXHIBIT "B"

CASH STATEMENT—JOURNAL FUND April 21, 1931, through April 15, 1932

Receipts

4	
As per last audit (overdraft)\$	4,536.97
Earnings from Advertising	
(Exhibit "E")\$ 2,912.13	
Subscription and Miscellaneous	
Sale of Journal	
Bonus from Cooperative Med. Adv.	
Bureau 262.70	
From General Fund 2,838.00	6,024.23
Total Cash to be Accounted for\$	1,487.26
Disbursements	
Postage and Supplies \$ 197.96	
Telephone and Telegraph 64.46	
Salaries 2,335.55	
Editor's Salary 583.33	
Printing of Journal & Electrotypes 3,763.15	
Auditing Expense	
Convention Expense 40.57	
Bond of Treasurer 26.25	
Office Rent 97.50	
Incidental Expense	7,148.39
-	
Balance—Overdraft\$	5,661.13
Plus Balance General Fund	16,352.95
Plus Balance Exhibit Fund	
Net Cash Balance in Bank\$	11,100.44
EXHIBIT "C"	
CASH STATEMENT—EXHIBIT FUN	D

April 21, 1931, through April 15, 1932

Receipts Cash as per last audit\$ 390.06

Earnings from Technical Exhibits. 410.00	
Total Cash to be Accounted for	\$ 8
Disbursements	

Disburs	ements		
Postage and Supplies	5.28		
Telephone and Telegraph	4.62		
Salaries	2.13		
Convention Expense	79.11		
Drawing, Printing, Sign			
Painting, etc	54.30		
-		145.44	
To Entertaining Society (Or		126.00	
To Entertaining Society (Sar:	asota)	120.00—	391.44

00.06

EXHIBIT "D"

DUES COLLECTED APRIL 21, 1931, THROUGH APRIL 15, 1932

	Total	No. Paid	No. in	1932 Dues	Back Dues
Name of Society	Members	Members	Arrears	Collected	Collected
Alachua	22	16	6	\$ 150.00	\$ 30.00
Bay	8	5	3	40.00	10.00
Brevard	9	7	2	60.00	40.00
Broward	19	16	3	150.00	10.00
Columbia	7	6	1	50.00	20.00
Dade	156	85	71	840.00	1,180.00
DeSoto-Hardee-Highlands	18	8	10	70.00	20.00
Duval	150	94	56	930.00	460.00
Escambia	37	21	16	190.00	140.00
Hillsboro	88	48	40	470.00	270.00
Individuals	6	1	5		
Jackson	15	11	4	100.00	20.00
Ľake		17	0	160.00	10.00
Lee	10	9	1	80.00	
Leon-Gadsden-Liberty-Wakulla-Jefferson	29	23	6	220.00	10.00
Madison	3	2	1	10.00	
Manatee	13	13	0	120.00	
Marion	17	1.2	5	100.00	70.00
Monroe	3	3	0	20.00	
Orange		39	12	360.00	10.00
Palm Beach	42	37	5	360.00	110.00
Pasco-Hernando-Citrus		9	5	80.00	
Pinellas	73	60	13	580.00	610.00
Polk	57	46	11	450.00	30.00
Putnam		5	2	40.00	
St. Johns	11	11	0	100.00	
St. Lucie-Okeechobee-Indian River-Martin	11	10	1	90.00	10.00
Sarasota	12	12	0	110.00	
Seminole	11	11	0	100.00	
Sumter	3	3	0	30.00	
Taylor		7	0	60.00	
Volusia	35	15	20	140 00	70.00
Walton-Okaloosa	7	7	0	60.00	
Washington-Holmes*					10.00
	968	669	299	\$6,320.00 3,140.00 Ba	\$3,140.00 ck dues collected
*13 1 * 4040					

*Dropped in 1932.

\$9,460.00 Total dues collected

is topped in 1952		
EXHIBIT "E"		
EARNINGS FROM ADVERTIS	SING	
April 21, 1931, through April 15		
7 7 2	*	207.70
May, 1931		287.78
June		224.87
July		290.58
August		243.41
September		278.67
October		244.09
November		249.72
December		189.71
January, 1932		200.99
February		164.46
March		150.59
April		387.26
	_	
Total	\$2	2,912.13
EXHIBIT "F"		
NAMES OF MEMBERS DROPPED BY	REASO	OV OF
REMOVAL, NON-PAYMENT OF D		
April 21, 1931, through April 15	1932	10.
71pm 21, 1751, through 71pm 75	Dues No	t Paid
Name and Address	931	1932
ALACHUA COUNTY MEDICAL SOCIETY:		
	0.00	10 00
	0.00	10.00
	0.00	10.00
,	0.00	10.00
	0.00	10.00
Treeming trees, trees of trees governor trees	0.00	10.00
The month of the state of the general terms	0.00	10.00
	0.00	10.00
COLUMBIA COUNTY MEDICAL SOCIETY:	0.00	
Arnold, L. J., Lake City	0.00	

Arnold, L. J., Lake City...... 10.00

Non- and Address	Dues Not	
Name and Address	1931	1932
HILLSBORO COUNTY MEDICAL SOCIETY: Cook, H. M., Tampa	10.00	10.00
Daniels, Benjamin A., Tampa	10.00	
Faver, H. M., Tampa	10.00	10.00
Jefferson, Rollin, Tampa	10.00	10.00
Knight, J. C., Plant City	10.00	
Meighen, D. G., Tampa	10.00	10.00
Smith, Burdette, Tampa	10.00	
LEE COUNTY MEDICAL SOCIETY: Stone, George S., Ft. Myers	10.00	*
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFER	SON	
County Medical Society: Daves, F. E., Chattahoochee	10.00	*
Glover, George B., Monticello	10.00	10.00
Harrison, A. P., Crownsville, Md	10.00	10.00
Murrow, J. S., Apalachicola	10.00	10.00
MADISON COUNTY MEDICAL SOCIETY:		
Marion County Medical Society:	10.00	*
Curry, J. F., Dunnellon	10.00	
Strickland, E. E., Citra	10.00	
Stutts, Baldwin S., Dunnellon Turner, S. L., Williston	10.00	
ORANGE COUNTY MEDICAL SOCIETY:	10.00	
Jones, Allan (to Dade County), Miami		10.00
PALM BEACH COUNTY MEDICAL SOCIETY:		00
Henry, Gordon F., West Palm Beach Herman, F. Peter, West Palm Beach	10.00	$10.00 \\ 10.00$
Newton, S. B., Summit, Pa	10.00	
Spooner, D. S., Pahokee	10.00	
Pinellas County Medical Society: Anderson, W. D., Largo	10.00	10.00
Davies, Ray, St. Petersburg	10.00	10.00 10.00
Dickerson, L. B., Clearwater	10.00	10.00
Fisk, Harley B., St. Petersburg Gable, N. Worth, St. Petersburg	10.00	10.00
Green, T. H., Knoxville, Tenn	10.00	
Groves, W. H., Clearwater	10.00	10.00
Harden, W. W., St. Petersburg Hardenbergh, John A., St. Petersburg	10.00	$10.00 \\ 10.00$
Heibner, E. A., St. Petersburg	10.00	
Kumin, Fred F., St. Petersburg	10.00 10.00	10.00
Mighell, Norman E., Clearwater	10.00	10.00
O'Brien, R. K., St. Petersburg	10.00	
Peabody, J. D., St. Petersburg Pierce, L. H. (deceased), Kalamazoo,	10.00	
	10.00	
Mich. Reiger, O. P., Wierton, W. Va	10.00	
Sackett, Harry R., St. Petersburg POLK COUNTY MEDICAL SOCIETY:	10.00	
Ragsdale, V. H., Pierce	10.00	*
Roberts, Tenney Hugh, Lakeland	10.00	10.00
Putnam County Medical Society: Brantley, Z., Grandin	10.00	10.00
Rosborough, D. Y., Palatka	10.00	10.00
ST. LUCIE-OKEECHOBEE-INDIAN RIVER		
MARTIN COUNTY MEDICAL SOCIETY:	10.00	*
Council, M. D., Ft. Pierce	10.00	10.00
McDermid, H. C., Okeechobee		10.00
Volusia County Medical Society: Genge, Victor P., Daytona Beach	10.00	10.00
	SOCIETY:	
Coleman, W. E., Chipley Dawkins, N. J., Vernon	10.00	
Harper, C. W., Chipley	10.00	
Individuals:		
Airth, H. F., Live Oak	10.00	

Name and Address Price, J. M., Live Oak	1931 10.00	Not Paid 1932
Dues of Secretaries	5910.00 10.00 20.00	\$380.00 310.00 50.00
	940.00	740.00 940.00
Total*Reinstated.		\$1,680.00

ASSETS AND LIABILITIES April 15, 1932

:1	55	cts	
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Cash in Bank	\$ 3,587.73
General Fund-Accounts Receivable	2,990.00
Furniture & Fixtures (less depreciation)	204.98
Library	103.55
Stationery Inventory	38.21
Savings-Barnett National Bank	7,512.71
Investment (Treasury Bonds)	10,178.13
	\$24 615 31

r t . 1 tirkt

		L	iabilities		
Journal Capital	Fund—A Account	ccounts	Receivabl	e	7.00 24,608.31
					\$24,615,31

Dr. W. M. Rowlett of Tampa moved that the joint report of the Secretary-Treasurer and Business Manager be accepted. Motion seconded and carried.

The report of the Executive Committee was then presented by Dr. Gerry R. Holden, chairman:

REPORT OF EXECUTIVE COMMITTEE

The Executive Committee held its initial meeting at Orlando immediately after the conclusion of the State Association meeting in May, 1931. At this time the expenses of running the Association for the ensuing year were considered, a budget was adopted and Dr. Stewart Thompson was chosen Business Manager for the coming year. It was also voted to pay \$200.00 into the treasury of the Dade County Medical Society, reimbursing this society in part for monies paid out by it in 1930 on account of legal activities. This expense had been authorized by the action of the State Association in 1929 but had never been paid.

Various other meetings have been held throughout the year as they were required and the Committee has acted in its executive capacity whenever necessary. Possibly the most important action taken was the physical separation of our business office from that of the State Board of Health. While the Association has had an office room of its own for some time we have utilized the employees and equipment of the State Board of Health, paying for such services at overtime rates. We have never received anything from the State Board of Health that we did not pay for. Nevertheless, such an arrangement was hardly fair to the State Board of Health as it might lay this body open to possible criticism. Therefore, all our activities are now carried out in an office of our own with complete equipment which belongs to us. We also have a full-time stenographer of our own and no facilities of the State Board of Health are used by us.

This change has not entailed any additional expense of any moment as we already had considerable office equipment of our own and the necessary articles which were lacking we obtained, through a fortunate purchase negotiated by Dr. Thompson, for a nominal sum. We were also fortunate in securing the services of a highly trained stenographer and bookkeeper without increasing the amount allotted by our budget for stenographic work.

The running expenses of the Association have been materially reduced during the year. The Record Company granted a reduction in the cost of printing the Journal. Both Dr. Richardson, our Secretary, and Dr. Thompson, our Business Manager, made voluntary reductions in their salaries. The total of these savings will amount to more than \$1,000.00 a year.

At its meetings throughout the year the Executive Committee has considered in detail various suggestions which have been made both verbally and in the Journal with the intent to facilitate the handling of the affairs of the Association and to make it of greater benefit to its members. As a result of these deliberations we wish to make the following recommendations:

- 1. We recommend that the various changes in the Constitution and By-Laws as outlined by our President and his committee be adopted. We wish particularly to stress the importance of that change which provides for a President-elect. This is in accordance with modern custom and we believe that it will help greatly in the work of our Association.
- 2. We recommend that the State Association take a more active part in assisting local county societies in their endeavors to rid the State of physicians or healers of any sort who are carrying on their activities in violation of the laws of Flor-

- ida. While we believe that the active work in each specific instance should be done by the local county society, we do feel that the Association can be of much more help than it has been in the past and with this thought in mind the next three recommendations are made.
- 3. We recommend that the incoming Executive Committee be authorized by the House of Delegates, to reimburse Dade County Society for a portion of the money which it has spent during the past year in running down and apprehending irregular practitioners. This Society has been very active in this work and has thereby benefitted the entire State. Inasmuch as it has spent much money from its own treasury we recommend that it be reimbursed to the extent of \$200.00 providing that this amount does not exceed 50% of all such expenses for the current year collected and paid out by the Dade County Society for this work.
- 4. We recommend that the State Association retain the services of a legal firm of high standing to act in advisory legal capacity to our Association and its component and associated societies, if such can be obtained at a yearly expense of not over \$100.00. This means legal advice given at the offices of the Attorneys and does not include prosecution of cases or other extraordinary services. Your committee is assured that such services can be secured, for the next year at least, within this cost limit.
- 5. We recommend that the State Association give financial aid to County Societies in their efforts to rid the State of unlicensed practitioners in the following manner: That the State Association match dollar for dollar, cash deposited by component County Societies with the State Association's treasurer, this cash to be used for medico-legal activities in said counties. The total amount put up in any one year shall not exceed 50% of the total State dues paid in by that Society during the year and in cash shall not exceed \$200.00 for any one year.

Each request for such financial aid shall be considered by the Executive Committee and no request shall be granted unless authorized by unanimous consent of the Executive Committee. Money received from any component society shall be set up in the State Association books, with a like amount of the Association's funds, to the credit of that County Society. This fund is to be under the jurisdiction of the Association's Executive Committee and no obligations are to be

irentred against this fund without such obligations first being approved by the Executive Committee. Invoices of bills for such approved expenditures shall be filed with the business manager of the Association, covering items of authorized expenditures, and the Association's check shall be issued in payment thereof. No payment for expenditures can be made except by means of the State Association's check bearing the signature of the treasurer of the Association.

6. We recommend that the President be authorized to increase the Committee on Legislation and Public Policy by the addition of as many members as he considers necessary.

The above recommendations are made with the understanding that the State dues remain at \$10.00 per year. Should the Association vote to reduce the dues these recommendations will have to be modified or withdrawn.

Respectfully submitted.
Gerry R. Holden, Chairman;
M. J. Flipse,
W. H. Spiers,
Shaler Richardson,
Member ex-officio;
Gaston H. Edwards,

Member ex-officio.

Motion made by Dr. John S. Helms that the report of the Executive Committee be accepted; that the three provisions, including the financial expenditure, be acted upon by the House of Delegates; and that recommendation No. 6, which would mean a change in the By-Laws of the Association, be referred to the House of Delegates and acted upon at the General Session the following day.

The above motion was duly seconded and carried.

The following report of the Public Relations Committee was read by Dr. J. Ralston Wells, secretary of the committee:

REPORT OF PUBLIC RELATIONS COMMITTEE

The Public Relations Committee has met six times. The Executive Committee has been represented in person by one or more of its members at each of these meetings.

The general lines of Chairman Dozier's aims, as outlined in his Presidential Address, have been followed, together with those of the Illinois State Medical Association with such alterations as were

considered expedient for the particular needs of Florida. The further we proceeded, the larger the proportion of our work became. It was deemed inadvisable to carry out all the aims the first year, and therefore three of the four major objectives were decided upon for 1931, namely, the Radio Bureau, the Press Bureau and the Motion Picture Bureau. The Speakers' Bureau has not as yet been developed.

Our *first* objective was to "sell" the idea to the medical profession in various parts of the state; *second*, to collect all available medical literature from any source whatsoever that would or could have some bearing upon our proposed work; *third*, to correlate this mass of material and adapt its form to that which would be appropriate to Florida's usage; and *fourth*, to put it before the Florida public in such a manner that it would medically educate them for their own good, teach them the difference and the value of medicine in the distinction to various cults, practices and quacks, without, however, any individual physician's name appearing in any manner whatever, and without being offensive.

The Radio Burcau.—This Bureau has been functioning smoothly. It is composed of two parts. The first is a major program for the entire year. This has been mapped out as coming directly from men interested in and connected with headquarters of the State Medical Association. Station WRUF, University of Florida, Gainesville, has cooperated to the fullest extent.

The program consisting of the following topics has been blocked out, dates set, and up until the present each appointment has been fulfilled with a considerable degree of success:

- (1) Some Interesting Medical History in Florida.—Oct. 14, 1931.
- (2) The Florida Medical Association; What It Is and the Value of Its Influence to the State.

 —Nov. 11, 1931.
- (3) The Medical Profession.—Dec. 30, 1931.
- (4) The Medical Profession; Its Contribution to Charity in the State of Florida.—Jan. 6, 1932.
- (5) The Medical Profession; Its Economic Contributions to the State of Florida.—Feb. 10, 1932.
- (6) The Medical Profession; Its Value to Society.—March 16, 1932.
- (7) The Value of a Hospital to a Community.—April 20, 1932.

- (8) What Internal Medicine has Contributed to Society.—May 21, 1932.
- (9) What is a Class A Hospital, Its Security to the Patient and Its Value to the Doctor.
- (10) The Florida State Hospital Association; Its Aims and Aspirations for the Good of the Public.
- (11) The Florida State Board of Health.

The second department of the Radio Program depends upon local societies that have broadcasting stations in their vicinity: Station WJAX, in Jacksonville; station WDAE in Tampa; station WDBO in Orlando; station WQAM in Miami. These stations have been used regularly for definite periods, the local medical society in each vicinity furnishing the speakers. The radio stations in question have afforded us courteous cooperation. Each talk is preceded by an announcement that it is the Florida Medical Association talking. Manuscripts of all talks are demanded and are signed by the doctor writing them, his name appearing only in the files of the radio station for authenticity. These talks are reviewed, censored, and passed by a member of this Committee, and are filed with the Public Relations Committee. They may be original articles or articles more or less rewritten from those obtained from any of our sources of information.

The Radio Program is, in its entirety, with minor disturbances, functioning in its first year, very well.

The Press Bureau.—The entire press of Florida has been circularized. The Committee collected, or received, thirty-one articles, either original or rewritten, from various members of the Florida Medical Association. Each article is three hundred to four hundred words in length and is ready for press publication.

Starting with December 16, 1931, and carried through to February 9, 1932, articles were released one each week. These articles were released at a time when their topic was thought to be the most useful to the Florida reading public.

There were approximately one hundred and seventy (170) copies sent each week to the Florida newspapers; of these not over fourteen (14) were used during any one week. Your state officers, State Executive Committee, and the Public Relations Committee came in for some rather rough verbage from several small-town newspaper editors; their idea seeming to be that the medical profession was endeavoring to obtain "something for nothing", namely free adver-

tising. The State Executive Committee felt that because of the considerable labor necessary for these publications, the necessary expense, the poor response, and the adverse criticisms, that this phase of our program should be in some way rearranged.

It might not be amiss to state here that these difficulties of the Florida Medical Association are almost an identical duplication of the difficulties experienced by the Illinois State Medical Association several years ago. The rearranged plan that this Committee has adopted, and which was agreed upon by the Executive Committee, is as follows: a letter has been sent to each editor in the state, stating that we are willing to release these articles, which are of value to the newspaper reading public if the particular editor wishes them. If he does not, he will not receive them. A member of the Florida Medical Association in each community has been asked to personally get in touch with his local editor and to explain the endeavors of the State Association, attempting to impress particularly that these articles are not advertising propaganda for the profession, but that they are of general medical educational value to the reading public, and, furthermore, that they are in most instances of more value to the local needs of Florida than any syndicated articles such as written by Doctor Fishbein, Doctor Clendening, etc., which are daily published by numerous Florida newspapers.

Your Committee has been instrumental in advising several county societies against making an outlay of money for a set of copyrighted articles to appear in the local press. It was explained that the State Association is attempting, through this Committee, to spread similar propaganda, with more educational value, and through more diversified channels including the press, thereby making a saving to the county society and individual members.

The Motion Picture Bureau.—This Bureau has ascertained sources for medical and medical educational motion pictures, and has on file at present five available sources, with a total of thirty-eight (38) films; eighteen (18) of which are on the rental plan, and twenty (20) free. Of these twenty, free films, three (3) have the transportation paid one way only, and seventeen (17) have the transportation paid both ways with the use of a projector and an operator without cost if requested.

Your Committee has made pleasing and helpful contacts with similiar Public Relations Committees in Illinois, Texas, and Pennsylvania.

We feel that for the first year the activities of this Committee have met with success, and that at least a start based upon sound principles, has been made.

Respectfuly submitted,

H. C. Dozier, Chairman;
J. Ralston Wells, Sec'y;
J. M. Irwin,
J. S. McEwan,
Ernest B. Milam,
Henry E. Palmer,
W. C. Payne,
Homer L. Pearson,
J. A. Simmons,
H. Mason Smith.

On motion duly made, seconded and carried, the above report was adopted.

The following report of the Committee on Legislation and Public Policy was presented by Dr. W. M. Rowlett, chairman, of Tampa:

REPORT OF COMMITTEE ON LEGISLA-TION AND PUBLIC POLICY

The Committee on Legislation and Public Policy has had very little to do relative to legislative matters on account of this being an off year for the Legislature.

We feel, however, that it is of the utmost importance that men of the highest calibre, in sympathy with the ideals of organized medicine, be elected to the Legislature. We, therefore, earnestly beseech that each of you, upon your return home, go into action and organize your Society for this purpose. Where it is possible, we should encourage medical men to run for the Legislature. At the present time, we have three physicians who are candidates for the Senate and two for the House. We feel confident that this number could be doubled if a little effort were made, although, most important of all, is to see that they are elected. Any man that has ever served on the Legislative Committee will tell you that an intelligent physician in the Legislature is worth more to us than all the lobbyists and money we can send to Tallahassee, when endeavoring to pass or defeat a bill.

At the last Legislature your Committee, with the splendid cooperation of Doctors Turner, Dell and Chowning of the Senate, and Doctor Coffee of the House, assisted in the passage of several bills, including the Midwifery Act, which provides for an examination of the applicant by the State Board of Health. We also succeeded in defeating several obnoxious bills. We were very jubilant over getting by without costing the Association anything. By establishing contact with our friends in the Legislature, we were able to receive copies of bills as soon as they were introduced. After a hasty study of them with the officers of the Association, we would report back to our minute men. We find that organized medicine throughout the U. S. in 1931 succeeded in defeating proposed cult bills. In Pennsylvania, a bill for creating a Board of Neuropath Examiners was defeated. In California, a bill providing for a Board of Masseurology Examiners met with defeat. There was also defeated in Illinois proposed Naprapathy and Sanatology Boards, and in New York a Physio-therapy Board. In other States bills providing for the practice of hydro-therapy, mechano-therapy, thermo-therapy, and electro-therapy were introduced and defeated. Any of these cults may appear before the next Legislature with their proposed bills.

We find from the report of the State Board of Medical Examiners that last year there were fifty-five physicians licensed to practice medicine in Florida. Five applicants failed in their examination. Sixteen applications were turned down, eight on account of being graduates from low graded medical schools, six foreign applicants on account of their citizenship and inability to speak English, and two refused on account of their previous advertising methods. At their June meeting there were four licenses revoked. One defendant appealed his case to the Supreme Court, where it is still pending. Your Committee deplores the lack of support that the Board has received from some quarters of the profession in aiding them to maintain its high standard of educational requirements of the applicants. Last year the Board of one of the largest Hospitals in the State accepted as internes two graduates from class "C" schools, while the Medical Examining Board had refused to accept their applications.

Last month, the head of one of our best organized clinics, who takes an active part in this Association, circulated a letter endeavoring to

have the Board rescind its action in turning down another applicant from a class "C" school. The latter case, like one of the above internes, was an osteopath, who had received credit on his osteopathic credentials, and with only the mere addition of one term in the class "C" medical school, was given the degree of M.D. This method of becoming an M.D. has proven quite popular. It is rumored that an effort will be made at the next Legislature to amend our Medical Practice Act so as to require the Medical Examining Board to accept them. Their argument will be that organized medicine in Florida endorses them and the best Hospitals in the state accept them as internes. Then Florida is confronted with having her educational requirements reduced from among the highest of the states to the lowest.

Your Committee condemns as unethical those physicians who take advantage of that section of our Medical Practice Act that permits out-of-state practitioners being called into consultation, and under the guise of consultation, permit these itinerant physicians to use their office for holding highly advertised clinics and the sale of some "cure-all" device. We caution you to be aware of the three big F's, Frauds, Fakers and Faddists.

The present economic condition we believe is our greatest disturbing factor, which is causing others as well as some of our physicians, to get out of line. Industrial and state medicine, health insurance, benefit societies, etc., must be watched with great vigilance.

We recommend that our Association adopt the amendment of the American Medical Association regarding fee-splitting.

We again wish to congratulate Dr. Stewart G. Thompson for the efficient manner in which he has handled the annual registration. It has been of great aid in securing evidence against illegal practitioners. Dr. Thompson, cooperating with your Committee, will soon distribute the new directory of all those practicing the healing art. In this directory there will appear the practice act of each. We hope that every physician in the state will study the various laws in order to become better acquainted with their scope.

We believe that a "Preliminary Educational Board", fostered by some other organization than the medical profession, whose members would consist of college professors instead of medical men, offers the best solution of a single standard of qualifications for those practicing the healing arts.

In conclusion, we do not wish to be accused of being hostile or antagonistic. Many of you, along with the press and the laity, love an internal scrap, but remember our prestige sinks every time it occurs. Our object in sounding the above warnings is to cause you to stop, look and listen.

In times of emergencies we usually get together, but ofttimes it is too late. Let us now take time by the forelock.

Respectfully submitted,
W. M. Rowlett, Chairman;
J. C. Davis,
S. E. Driskell.

Dr. John S. Helms, Tampa:

"I honor and respect Dr. Rowlett, and I value most highly his services on this committee. He has served for many years. I do feel, though, that in making his report this morning Dr. Rowlett has, in his enthusiasm to put over a picture of the situation as it is in this state, become a little over-enthusiastic and that he has not made a complete presentation of all of the facts that pertain to some of the activities that were put forth. I know that every one in this house has applied the question to himself, as to what prominent hospital in the State of Florida employed, through their Board of Directors, two men who had graduated or were supposed to have received diplomas from class "C" medical schools. Since Dr. Rowlett has not told you the name of that hospital, I am going to tell you, myself—the Tampa Municipal Hospital, upon which staff Dr. Rowlett is a prominent member. This is a semipolitical hospital, and the members of the board of directors were at that time all laymen. They were the ones responsible for the appointment of these internes. Dr. Rowlett, being on this staff, had this information at hand. He should have made an objection to the appointment of these internes. This matter was called to the attention of the board of directors and of the staff, and the man that got his diploma from the class "C" institution after getting credit from an osteopathic school was entirely eliminated from the hospital. The other man has agreed to take his full four years' course in a class "A" school. I think that the hospital management should deserve some credit for having taken this action in the first place, and for their influence in having this young man register for a regular course in a class "A" institution, thus putting him on the right track.

With these preliminary remarks, by way of explanation, I desire to make a motion that this most excellent report presented by Dr. Rowlett be made the action of this body."

Motion seconded by Dr. John E. Boyd.

Dr. W. M. Rowlett, Tampa:

"I had furnished the superintendent of the Municipal Hospital in Tampa a list of all of the colleges in the United States and their classes. This appointment was made when I was away on my vacation, and as soon as I returned I reported the fact to the superintendent, but apparently it was completely ignored."

Upon open vote, Dr. Rowlett's report was unanimously adopted.

Motion made by Dr. Holden to adopt the recommendation contained in Dr. Rowlett's report, that this Association go on record as opposed to fee splitting. Seconded and carried.

Dr. John E. Boyd then read the following report of the Committee on Hospital and Medical Education:

REPORT OF HOSPITAL AND MEDICAL EDUCATION COMMITTEE

The past year, as was the case during the previous one, has seen very little activity or real progress made by the hospitals of the state, owing, we feel, entirely to the continued financial depression and not to any lack of effort or enthusiasm on the part of the hospital authorities. In fact, we feel that much credit is due the controlling boards of these hospitals because of their having successfully continued their previous standard of good service.

Your Committee has not been inactive. In fact, it has during the past year put forth a special effort to further a deeper interest in the matter of professional ethics. And, to this end, a discussion article on "Medical Ethics" has been read before a mixed professional audience under the auspices of numerous county societies throughout the state. The committee is glad to report that of those societies who were given the refusal of this article only two exhibited a sufficient indifference to fail the courtesy of a reply. The article was favorably commented upon wherever it was read. The members of the Association must understand that it was impossible to offer a good many of the county societies the refusal of its presentation because of the distance from the writer. The Committee finally submitted the article to the American Medical Association hoping it might be accepted for publication in its Bulletin, if not the Journal. However, it was returned with the statement that the manuscript reached them at a time they were greatly overcrowded with material and were returning practically everything sent them on account of lack of space; they further said the material was not especially suited for publication in the Journal.

The greatest disappointment experienced by the members of your committee deals with their failure to help the hospitals of less than twentyfive beds or to stimulate them to undertake some definite improvement in their standard. The question naturally arises, after a lapse of two years, as to whether the "minimum standard" which was offered by this committee, approved by the executive committee, and adopted by the House of Delegates is too drastic or not. The main reason for such personal interest in these smaller hospitals is because of the fact that the standardization program of larger organizations do not include the hospitals of less than twenty-five beds. It is felt by all, however, that these small hospitals have a definite place in the general hospital scheme and, therefore, deserve all the help that can be given them. The Committee invites a frank discussion on this point and in order that those present may have their memories refreshed on these minimum requirements they are herewith reread:

MINIMUM REQUIREMENTS

- 1. That physicians and surgeons privileged to practice in the hospital be organized as a definite group or staff.
- 2. That membership upon the staff be restricted to physicians and surgeons who are (a) full graduates in medicine in good standing and legally licensed to practice in the state; (b) competent in their respective fields; (c) worthy in character and in matters of professional ethics—that in this latter connection the practice of the division of fees, *under any guise whatever*, be prohibited; (d) members, in good standing, of their County Medical Society and the State Medical Association.
- 3. That staff meetings be held at least once each month; (a) each staff member be required to be present annually at 65% of the staff meetings; (b) clinical experience in the various branches—such as medicine, surgery, obstetrics and the other specialties, taken from hospital

cases,—be reviewed and analyzed; cases of death and those discharged unrelieved should receive special attention.

- 4. That accurate and complete records be written for all patients and filed in an accessible manner in the hospital—a complete case record being one which includes identification data; complaint; personal and family history; history of present illness; physical examination; special examinations—such as consultations, clinical laboratory, X-ray, and other examinations; provisional or working diagnosis; medical or surgical treatment; gross and microscopical pathological findings; progress notes; final diagnosis, condition on discharge; follow-up and, in case of death, autopsy findings.
- 5. That diagnosis and therapeutic facilities, under competent supervision, be available for the study, diagnosis, and treatment of patients—these to include, at least, (a) clinical laboratory providing clinical, bacteriological, serological and pathological services; (b) X-ray department providing radiographic and fleuroscopic services.

All of which is respectfully submitted.

THE MEDICAL EDUCATION AND HOSPITAL

COMMITTEE.

JOHN E. BOYD, Chairman;

R. O. LYELL,

JOHN S. HELMS.

Information that we did not obtain in time to incorporate in the body of this signed report is now added as a supplement.

A survey recently made by the representative of the American College of Surgeons removed three conditionally approved hospitals from our standardized list, but added four not previously approved. Thus, out of a total of forty-seven hospitals of twenty-five or more beds 32 instead of 31, as before, are on the standarized list.

So far as could be learned there are still forty hospitals in this state of less than 25 beds, none of which have been able to comply with the minimum requirements of the association. This only indicates that the committee's anxiety about the smaller hospital is justified.

There has been no change in the number of the hospitals carried on the Approved List for Internes of the American Medical Association. It might interest you to know that seven hospitals in the State receive no pay from patients.

JOHN E. BOYD, Chairman; R. O. LYELL, JOHN S. HELMS. Upon motion duly made, seconded and carried, the above report was adopted.

After some discussion as to the standard requirements relative to small hospitals, Dr. Helms made a motion that the President be asked to present this matter of the standard of requirements set up by this committee with respect to these hospitals, to the House of Delegates for their discussion of these particular requirements.

Motion seconded by Dr. Boyd, voted and carried.

On behalf of Dr. Robt. H. McGinnis, chairman, Jacksonville, Dr. Shaler Richardson then read the report of the Committee on Necrology.

REPORT OF COMMITTEE ON NECROLOGY

The Florida Medical Association has lost, by death, the following members since the annual meeting of 1931:

Robert Lee Bryans, Pensacola

E. T. Craney, Orlando

J. Brown Farrior, Tampa

James Q. Folmar, Chattahoochee

James E. Goethe, Jacksonville

Robert S. Lowry, Kingsville, Ohio (formerly of Ft. Lauderdale)

Sylvan McElroy, Orlando

H. A. Reaves, Jacksonville

Samuel D. Rice, Gainesville

Clarence T. Skipper, Jacksonville

Louis H. Van Engelken, Ocala

George W. Wood, Rockledge

These members have contributed their bit to the success of the organization and we feel their loss with profound sorrow. In their respective communities, tributes have been offered. They have rendered aid to suffering mankind in the sphere of clinical medicine and in the art of professional practice.

And now, in a minute of standing silence, we express our grief and dedicate a page in our minutes to their memory.

ROBERT H. McGINNIS, Chairman;

HARRY C. GALEY,

J. RAYMOND GRAVES,

JACK HALTON,

M. M. HANNUM,

E. H. McRAE,

L. A. Peek,

C. C. Webb.

The members of the Association then stood for a moment of silent respect.

Dr. Edwards then submitted the report of the committee appointed to amend the Constitution and By-Laws. Motion duly made, seconded and carried to accept this report.

SCIENTIFIC ASSEMBLY

At 2:00 p. m., May 3rd, the Scientific Assembly reconvened with Dr. O. O. Feaster, chairman of the Scientific Program Committee, in the

The following papers were read and discussed: "Hay Fever in Florida," Frank C. Metzger, Sarasota.

"Diabetes in the Home," Roscoe H. Knowlton, St. Petersburg.

"Chronic Infectious Arthritis," Julian E. Gammon, Jacksonville.

"Amelioration of Labor Pains," Robert G. Nelson, Tampa.

MEETING OF THE HOUSE OF DELEGATES

The meeting of the House of Delegates was called to order at 5:00 p. m., May 3rd, by Dr. G. H. Edwards, President.

The delegates elected by the various county societies were then called with instructions that if the delegates were not present, the alternates. if present, should be seated. The roll call of the secretary showed the following delegates, alternates or substitutes present:

DELEGATES

ALACHUA COUNTY MEDICAL SOCIETY-

W. C. Thomas

BREVARD COUNTY MEDICAL SOCIETY-

W. C. Page

BROWARD COUNTY MEDICAL SOCIETY-

E. M. Hendricks

COLUMBIA COUNTY MEDICAL SOCIETY-

L. M. Anderson

DADE COUNTY MEDICAL SOCIETY-

M. J. Flipse R. O Lvell

W. W. McKibben

C. E. Tumlin

R. C. Woodard

DeSoto-Hardee-Highlands County Medical Society-J. A. Simmons

DUVAL COUNTY MEDICAL SOCIETY-

L. W. Cunningham Gerry R. Holden

Luther Holloway

George Richardson

H. Marshall Taylor

ESCAMBIA COUNTY MEDICAL SOCIETY-

M. A. Lischkoff

HILLSBORO COUNTY MEDICAL SOCIETY-

W. P. Adamson

J. R. Boling B. W. Lowry

JACKSON COUNTY MEDICAL SOCIETY-

M. Q. Burns

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON

COUNTY MEDICAL SOCIETY-

John K. Johnston

MANATER COUNTY MEDICAL SOCIETY-T. M. McDuffee

MARION COUNTY MEDICAL SOCIETY-

J. N. Moore

ORANGE COUNTY MEDICAL SOCIETY-

J. R. Chappell Wm. H. Spiers

PALM BEACH COUNTY MEDICAL SOCIETY—

F. K. Herpel

W. L. Shackelford

PINFLLAS COUNTY MEDICAL SOCIETY-

W. M. Davis

O. O. Feaster

Grace Whitford 11. E. Winchester

POLK COUNTY MEDICAL SOCIETY-

J. L. Hargrove

PUTNAM COUNTY MEDICAL SOCIETY-

E. W. Warren

St. Johns County Medical Society-

J. M. Irwin SARASOTA COUNTY MEDICAL SOCIETY-

A. O. Morton

Volusia County Medical Society—

J. Ralston Wells

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY-

J. C. McSween

Bay, Lake, Lee, Madison, Monroe, St. Lucie-Okeechobee-Indian River-Martin, Seminole, Sumter, Taylor, County Medical Societies were not represented.

Upon motion by Dr. L. M. Anderson, duly seconded and carried, the newly appointed delegates were seated.

Motion made to dispense with the reading of minutes of last year's meetings, and to adopt the same as published in the May, 1931. Journal. Motion seconded and carried.

The President then called for the nomination of delegates to the American Medical Associa-

Dr. S. E. Driskell of Jacksonville was nominated regular delegate for a term of one year.

Motion made, seconded and carried to close the nomination, and the secretary was instructed to cast a ballot for Dr. Driskell.

Doctors M. J. Flipse of Miami and O. O. Feaster of St. Petersburg were nominated for alternating delegate for a term of one year.

Doctors J. R. Chappell and J. Ralston Wells were appointed tellers; Dr. O. O. Feaster, having received a majority of the votes cast, was elected.

The next order of business was the selection of a meeting place for 1933.

Dr. Henry Hanson was granted the privileges of the floor, and extended a cordial invitation on behalf of the Duval County Medical Society for the 1933 Convention to be held in Jacksonville.

Dr. Hanson's invitation was seconded by Dr. W. H. Spiers, of Orlando.

Dr. E. M. Hendricks, representing the Brow-

ard County Medical Society, invited the Association to meet in Hollywood. At the close of this invitation the privileges of the floor were accorded Mr. Clark of the Beach Hotel, Hollywood. Mr. Clark extended another sincere invitation on behalf of the citizens of Hollywood.

Dr. M. J. Flipse of Miami seconded this invitation, stating that the Dade County Medical stood ready to cooperate with Broward County in every effort to make the 1933 convention a success, should Hollywood be selected. Palm Beach County, through its delegate, also offered to cooperate.

Upon motion made, seconded and carried, the nominations were closed. Hollywood received a majority of the votes cast and was therefore designated as the meeting place for the next convention.

The following resolutions were read by Dr. M. J. Flipse of Miami:

WHEREAS, the 1927 session of the Florida Legislature, to meet a recognized need, passed an Act providing for the construction of a tuberculosis sanatorium, and appropriated funds for the same:

Whereas, the object of this Act has not been accomplished:

RESOLVED that the Florida Medical Association, in convention assembled, May 3, 1932, authorize and request its Executive Committee to use every effort toward the accomplishment of the provisions of this Act as provided for by law.

Upon motion duly made, seconded and carried, the above resolutions were adopted.

The following resolutions were then read by Dr. M. A. Lischkoff of Pensacola:

Whereas, All sorts of food and nutritional fads, supported by misinformation and exaggerated claims and involving grossly unbalanced diets are being advocated by various persons and agencies, and,

WHEREAS, Any diet, consisting of animal protein, fruits, vegetables, especially fresh and green vegetables, the better grades of bread made from flour which contains the necessary vitamins and mineral salts, digestible fats such as butter fat, and other easily assimilable carbohydrates to complete the energy requirements of the individual, is a balanced diet, and,

Whereas, The statements that meat, white bread, sweets, or other usual foods incorporated in a general diet are the causes of serious ailments, are not based on scientific facts, and,

WHEREAS, The results of dietary deficiencies have been grossly misstated by faddists, and

WHEREAS, Any special diet should be adopted only upon the prescription of a properly trained physician after complete study of the dietary necessities of the individual; therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association is in full accord with the statements made above and strongly disapproves on the basis of the danger to the public and individual health, of all food fads and special and unbalanced diets.

The above resolutions were seconded by Dr. Holden and unanimously adopted.

A resolution was read by Dr. L. W. Holloway of Jacksonville.

Dr. Holloway's resolution seconded by Dr. Anderson of Lake City.

Dr. Adamson of Tampa moved the amendment of Dr. Holloway's resolution by withdrawing the word "Repeal" and substituting therefor that it be referred to a vote of the people.

The amendment was accepted by Dr. Holloway and the following resolution adopted as amended:

Whereas, twelve years' operation under the Eighteenth Amendment has demonstrated to us as practicing physicians and citizens:

That it has promoted intemperance rather than temperance among the people of our country;

That diseases caused or promoted by excessive use of alcoholic beverages are steadily on the increase;

That the alcoholic beverages consumed under Prohibition are high in alcoholic content, often improperly made, and extremely toxic;

That the restraints imposed by Federal Law upon the right of a physician to prescribe alcoholic beverages are not only unreasonable and unjust, but are injurious, to patients and to the standards of our profession;

That social conditions have been profoundly damaged, and crime and immorality greatly increased;

BE IT RESOLVED, by the Florida Medical Association in Convention assembled:

- (1) That the Eighteenth Amendment to the Federal Constitution should be referred to a vote of the people and the problem of dealing with alcoholic beverages relegated to the several states of the Union.
- (2) That copies of this resolution be sent to each of the Senators and Congressmen representing Florida in the National Congress, and be furnished to the press.

The following resolution was then read by Dr. J. K. Johnston of Tallahassee:

WHEREAS, it is a custom of the Board of Commissioners of State Institutions to send to the State Hospital at Chattahoochee, employes of the state and their relatives for medical and surgical treatment; (these patients are only required to pay a nominal fee of \$3.00 per diem for hospital care, no fee being charged by the doctors in this institution.)

Whereas, the statutes of the State of Florida provides, "It shall be lawful for the superintendent of the Hospital for the Insane of Florida, when directed by the Board of Commissioners of the State Institutions to receive into said asylum any lunatic, idiot, or insane person whose friends, parents or guardians are able and willing to pay for the care and custody and maintenance of said lunatic, idiot or insane person." The section of the statutes providing for the admittance of pay patients only provides for, "Any lunatics, idiots or insane persons whose friends, parents or guardians are willing and able to pay for the care and custody of said lunatic, idiot and insane person."

THEREFORE, in view of the purpose of the statutes, which is apparently that of caring for the indigent insane of the state or such lunatic, idiot or insane person as may be able to pay for their care, custody or maintenance, that the Board of Commissioners of State Institutions would not be authorized by law to send sane or mentally normal patients to that institution for medical or surgical treatment, either at the expense of the state or upon payment for such accommodations.

THEREFORE, be it resolved that the Medical Association of the State of Florida go on record as opposing this prac-

tice of sending state employes or their relatives to the state hospital at Chattahoochee.

RESOLVED further, that this resolution be published in the JOURNAL and a copy furnished each member of said board.

Motion by Dr. Holloway to adopt the above resolution, seconded and carried.

Dr. W. H. Spiers moved the adoption of a resolution which appeared in the September 19th, 1931, JOURNAL of the American Medical Association relative to the provision of hospitalization of U. S. Veterans.

Dr. M. J. Flipse of Miami offered an amendment to Dr. Spiers' resolution to the effect that a committee be appointed by the president to follow out the suggestions contained in the abovementioned editorial.

Dr. J. Ralston Wells offered a further amendment to the above resolution to the effect that this committee be given the power to act in connection with the Executive Committee.

Dr. Spiers accepted these amendments and the resolution was adopted as amended.

The President then appointed Dr. M. J. Flipse, chairman, and Drs. W. H. Spiers and J. Ralston Wells as associate members to act on the above committee, and instructed them to confer with the Executive Committee.

Dr. Gerry R. Holden then read, separately, recommendations No. 3, No. 4, and No. 5, contained in the annual report of the Executive Committee, and on motions duly made, seconded and carried, each of the above named recommendations were adopted.

The next order of business was the discussion of the standard of hospital requirements, with particular reference to small hospitals, as brought out in the annual report of the Committee on Hospital and Medical Education.

Dr. John S. Helms, being granted the privileges of the floor, brought out the question as to whether or not the delegates felt that the requirements were too high, or whether it was a question of disinterest on the part of the hospitals.

After open discussion, Dr. Frederick K. Herpel of West Palm Beach offered a motion that the Association go on record as approving the action of the Committee on Hospital and Medical Education, and that there be no diminution or lowering of the required standards.

Motion seconded and carried.

Dr. G. H. Edwards then submitted for approval the proposed amended Constitution and By-Laws.

Motion by Dr. L. M. Anderson that the proposed amended Constitution and By-Laws be approved with the exception of the clause which provides for the payment of railroad fare for the delegates to the American Medical Association. Motion seconded and carried.

Motion made by Dr. J. M. Irwin of St. Augustine that the Committee on Legislation and Public Policy be instructed to draw up a bill which they consider fair to all concerned, to be presented, with the consent of the Executive Committee, at the next session of the Legislature in lieu of the compensation act.

Motion by Dr. M. J. Flipse to amend Dr. Irwin's motion to the effect that this matter be referred to the Executive Committee, if they deem it advisable.

Amendment accepted by Dr. Irwin. On motion duly made, seconded and carried, the above motion was accepted as amended.

Motion made by Dr. Gerry R. Holden that the question of the reduction of dues be taken up and settled at this meeting, and that the privileges of the floor be granted Dr. J. Ralston Wells. Seconded and carried.

Motion by Dr. Wells that the annual dues be reduced from \$10.00 to \$7.50. Motion lost, after the discussion brought out the fact that the additional funds would be needed to carry out the newly adopted recommendations and resolutions.

Dr. Wells then requested that the Secretary write each County Society explaining the methods of using these additional funds and the advantages gained thereby. Request overruled.

There being no further business to come before the House, on motion duly seconded and carried, the meeting adjourned.

SCIENTIFIC ASSEMBLY

The Scientific Assembly reconvened at 7:30 p. m., May 3rd, Hotel Sarasota Terrace, Roof Garden, and the following scientific papers were read and discussed:

"Hygiene of Swimming" (with motion pictures), H. Marshall Taylor, Jacksonville.

"Roentgenological Examination in the Differential Diagnosis of Abdominal Pathological Conditions" (with lantern slides), Frederick K. Herpel, West Palm Beach.

Paper No. 10, "Some Considerations of the Peptic Ulcer Problem" (with lantern slides), by Dr. J. Knox Simpson, of Jacksonville, was read by title only due to the lateness of the hour.

SCIENTIFIC ASSEMBLY

The Scientific Assembly reconvened at 9:00 a. m., May 4th, Hotel Sarasota, Roof Garden, with Dr. O. O. Feaster in the Chair.

The following scientific papers were read and discussed:

"Bronchial Asthma", E. Sterling Nichol, Miami.

"Urinary Obstruction, Recognition of Cause and Its Relief", Gideon Timberlake, St. Petersburg.

"Recent Progress in Juvenile Sinusitis", M. A. Lischkoff, Pensacola.

"The Diagnosis of Chronic Appendicitis", E. W. Bitzer, Tampa.

THIRD GENERAL SESSION

The General Session of the Florida Medical Association again convened at 12 noon, May 4th, Hotel Sarasota Terrace, Roof Garden. The meeting was called to order by Dr. G. H. Edwards of Orlando, President.

Motion by Dr. L. M. Anderson of Lake City that in order to comply with the Constitution and By-laws of this Association, the doctors who had been proposed for honorary membership be investigated by the Executive Committee. Seconded and carried.

Motion by Dr. J. L. Kirby-Smith of Jacksonville that the general session over-ride the action of the House of Delegates, and sustain the resolution as read before the House by Dr. Holloway, without the word "referendum" inserted on amendment. Motion lost.

The Chair announced that the next order of business would be the election of officers for the ensuing year.

Dr. Gerry R. Holden of Jacksonville was nominated for the Presidency by Dr. J. S. Helms of Tampa. Nomination seconded by Drs. A. H. Freeman and L. M. Anderson.

Dr. A. M. C. Jobson of Tampa was then nomnated for President by Dr. Sheldon Stringer of Tampa. Nomination seconded.

Motion made, seconded and carried to close the nominations for president.

Voted by ballot with Drs. W. H. Spires, E. G. Peek, and H. Watson acting as tellers. Dr. Gerry R. Holden was elected President.

Dr. G. H. Edwards then requested Drs. Joe Halton and J. S. Helms to escort the newly elected President to the Chair.

Dr. Edwards, the retiring President, presented

Dr. Holden with a gavel as a symbol of the authority vested in him, and expressed the wish that he always wield it with credit to himself and to his office in the Florida Medical Association.

Dr. Holden: "Gaston, in accepting this beautiful gavel, I want to express my appreciation on behalf of the Association for this gift: and if I can next year do one-half as well as you have done, I shall feel that I have achieved my purpose.

"I thank you, gentlemen, for the confidence you have displayed in me by making me your President. I can assure you that from the bottom of my heart I can say that to a Florida physician no greater honor can come than that you have given me. I love the State of Florida, and I love the Florida Medical Association, and the fact that you have made me its President, I can assure you, fills my cup to overflowing. I will try during the next year to be as good a President as I can for you.

"Your House of Delegates yesterday adopted a number of resolutions which are going to put this Association in a new field of activity. Our medical-legal activities in the past have been without any special program, mostly inaugurated on the spur of the moment, and while results have been obtained they have not always been what they should have been. I am going to enlist the aid of a whole lot of you, to get your ideas and to get your help, so that we can now formulate for this society a rational, progressive program which will protect your beloved State from the onslaughts of irregulars and which will finally make Florida's medical situation as clean as any State in the United States. That cannot be accomplished overnight. Possibly this year we can only set the foundation of our structure, but with your help and with the help of the committees who will work with me, I trust that we will be able to at least see something toward that end.

"Again I thank you most sincerely for this honor which you have placed upon me."

The Chair then called for the nomination of a first vice-president.

Dr. Jack Halton of Sarasota was nominated for first vice-president by Dr. W. H. Spires, seconded by Dr. A. H. Freeman. Upon motion duly made, seconded and carried, the nomination was closed and the secretary was instructed to cast the ballot for Dr. Halton.

Dr. Eugene G. Peek of Ocala was nominated second vice-president by Dr. L. M. Anderson, Lake City.

It was moved, seconded and carried that the nominations be closed and the secretary cast the ballot for the second vice-president.

Dr. W. C. Thomas of Gainesville was nominated third vice-president.

It was moved, seconded and carried that the cominations be closed and the secretary cast the ballot for the third vice-president.

Dr. Shaler Richardson of Jacksonville was nominated secretary-treasurer by Dr. Edwards. seconded by Dr. Helms, and unanimously elected.

Dr. L. M. Anderson was then appointed by Dr. Holden to present the past president's button to the retiring president, Dr. G. H. Edwards.

Dr. Anderson: "Mr. President, Fellow Members and Guests: It is indeed a very great pleasure to me to present this button to our retiring president, Dr. Edwards.

"It is made of gold with the associate colors of yellow and green. Gold, being one of the most valuable and lasting of metals, represents your outstanding service to our association and the medical profession.

"Yellow means constancy which you have put, both in earnest endeavor to better our Association and the profession as a whole, and in the faithful and fair discharge of your duty.

"The color green means growth, emblematic of your growth in our Association; in your chosen profession, and in your constant and untiring effort to always pull for that which is right.

"We hope that you will wear this button with this in your mind—that you have received the highest honor conferred by our Association and now we have put the stamp on you as having done your duty as president of our Association to your constituency and to your profession.

"You are now the youngest past president of our Association standing in the world not as a finished product but as one who can still do greater things."

Motion by Dr. Osincup of Orlando that the Association extend a rising vote of thanks to the members of the entertaining society.

Motion amended to extend to these doctors and the citizens of Sarasota a vote of thanks for their kind entertainment, and for looking out for our comfort and convenience during the convention.

Amendment accepted and unanimously passed. There being no further business to come before the Association, on motion made, seconded and carried, the session adjourned, sine die.

SCIENTIFIC ASSEMBLY

The fifth session of the Scientific Assembly convened at 2 p. m., May 4th. The following papers were read and discussed:

"Blood Pressure", T. M. Rivers, Kissimmee. "The Modern Treatment of Syphilis and Some of Its Complications", Frank Wilson, Jacksonville.

"Endocervicitis", W. J. Johnston, Sarasota.

REGISTRATION

The total registration during the Fifty-Ninth Annual Meeting of the Florida Medical Association, held in Sarasota, May 3rd and 4th, was 366; members, 282; visitors, 31; Woman's Auxiliary, 53.

OFFICERS

Edwards, G. H., PresidentOrlando
Jobson, A. M. C., First Vice-PresidentTampa
Halton, Joseph, Second Vice-PresidentSarasota
Richardson, Shaler, Secretary-TreasurerJacksonville
Thompson, Stewart, Business ManagerJacksonville

Alachua County Medical Society

Dailey, I. A.	. Micanopy
Dell, J. Maxev	Gainesville
DePass, M. H	Gainesville
Thomas, W. C.	Gainesville
Tillman, Geo. C	Gainesville
Whitaker, C. D	Raiford

Brevard County Medical Society

Hay, I. M			 		 		 					M	el	lbourne
Kenaston,	T.	C.	 	 	 	 	 				 			. Cocoa
Page, W.	C.		 	 	 		 				 			. Cocoa

Broward County Medical Society

Brown, Oliver CFt.	Lauderdale
Connor, A. B.	. Hollywood
Hendricks, E. M Ft.	Lauderdale
McLaury, Elbert	. Hollywood
Peavy, H. JFt.	Lauderdale
Robinson, Leigh F Ft.	
Stovall, R. HFt.	Lauderdale

Columbia County Medical Society

Anderson, L.	M.	 	 Lake	City
Bates, T. H.		 	 Lake	City

Dade County Medical Society

Cleghorn, Chas. D
DuPuis, J. GMiami
Flipse, M. J
French, Elmo DialMiami
Haggard, Wm. AMiami
Harris, Robt. MMiami
Holmes, R. JMiami
Hutson, T. W
Jones, W. C., JrMiami
Lyell, R. OMiami
McKibben, W. WMiami
Maxwell, E. BMiami
Nichol, E. SterlingMiami
Norton, Richard C
Owens, Duncan
Palmer, B. HMiami
Panettiere, CayetanoMiami Beach
Payton, F. J
Pearson, Homer L., JrMiami

Phillips, KennethMiami	Province II O
Quillian, Warren	Brown, H. O
Raap, GerardMiami	Carlton, L. F
Simpson, J. R Ft. Lauderdale	Cook, Geo. L
Smith, M	Cowart, J. T
Snyder, J. W Miami	Dickinson, J. C
Stewart, J. S Miami	Duke, R. R
Tumlin, C. E	Duncan, W. P
Walker, H. A Miami Beach	Ely, R. A
Walters, A. L	Estes, J. LTampa
Weiland, A. H	Garcia, Parsons MTampa
Wood, A. WMiami	Gilbert, Elsie
Woodard, Robt. C	Gilmer, E. S
Youmans, I. C	Grable, J. S Tampa
	Helms, John S
DeSoto-Hardee-Highlands County Medical Society	Helms, John S., Jr
Eide, A. TLake Placid	Henderson, R. P
Kayton, M. CWauchula	Higgins, A. F
Kirkpatrick, C. H	Lowry, B. W
Martin, Leldon Wails Sebring	McEachern, J. R
Simmons, J. A Arcadia Touchton, W. C Avon Park	McRae, E. H
rodenton, w. C	McMurray, H. E
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Duval County Medical Society	Martin D. DTampa
Blackmar, R. W. Jacksonville	Mills, Herbert R
Blitch, Clifford G	Mills, John H
Boyd, John E Jacksonville Brink, F. A	Moore, John T
Cunningham, L. WJacksonville	Nelson, R. G
Driskell, S. E Jacksonville	Oppenheimer, L. S
Eaton, Paul	Patterson, Wm
Field, T. S Jacksonville	Rowlett, W. M
Fort, F. L Jacksonville	Rudisill, C. A
Gammon, Julian E Jacksonville	Saxton, J. JTampa
Hanson, Henry Jacksonville	Smith, H. Mason
Harris, W. G. Jacksonville Holden, Gerry R. Jacksonville	Spengler, N. L
Holloway, L. W	Stringer, Sheldon
Jelks, Edward Jacksonville	Taylor, J. W
Jennings. C. L Jacksonville	Vinson, J. C
Kirby-Smith, J. L Jacksonville	inson, j. C
Kirk, W. W Jacksonville	Jackson County Medical Society
Limbaugh, Louie M Jacksonville	
	Burns, M. QBlountstown
McIver, Robt. B Jacksonville	Burns, M. Q
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Jordan, W. BOcala	Wilhoyte, R. ELake Wales
Lindner, E. GOcala	But an Court Malinia
Moore J. NOcala	Putnam County Medical Society
Peek, Eugene GOcala	Drexel, A. E
Strange, J. L	Warren, E. W
	St. Johns County Medical Society
Orange County Medical Society	Grace, Chas. C
Andrews, L. L. Orlando	Irwin, J. M St. Augustine
Brinson, II Kissimmee	Lockwood, Vernon A St. Augustine
Chappell, J. R Orlando	Potter, Geo. W
Christ, C. D Orlando	Totter, Geo. WSt. Augustine
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Day, II. AOrlando	Medical Society
Dodds, Wm. H St. Cloud	Claxton, W. A
Folsom, Spencer A Orlanda	Davis, C. LOkeechobee
Geiger, II. SKissimmee	Whiddon, L. LFt. Pierce
Gray, F. DOrlando	
Johnston, HewittOrlando	Sarasota County Medical Society
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Pines, John A Orlando	Crihbins, O. HSarasota
Osincup, G. S Orlando	Halton, JackSarasota
Rivers, T. M Kissimmee	Harris, J. ESarasota
Sinclair W. EOrlando	Johnston, W. JSarasota
Spiers, W. HOrlando	Kennedy, David R Sarasota
	Metzger, F. C
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Dawson, Geo. M W. Palm Beach	Myers, N. P
Gunter, T. DW. Palm Beach	Patterson, J. C
Herpel, F. K	Taylor, T. W
Johnson, Vesey M W. Palm Beach	Wilson, C. B
Netto, L. J	, and the second
Peek, Leon A	Seminole County Medical Society
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Shackelford, W. L	Knox, A. WSanford
	Puleston, SamuelSanford
Pasco-Hernando-Citrus County Medical Society	Selman, G. S
Dame. Geo. A Inverness	
Hamblin, A. CValrico	Volusia County Medical Society
Jackson, Thos. F Dade City	Green, Geo. M Daytona Beach
	Green, Geo. M. Daytona Beach Miller, B. E. New Smyrna
Pinellas County Medical Society	Green, Geo. M. Daytona Beach Miller, B. E. New Smyrna Myres, M. J. Daytona Beach
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OUR PRESIDENT

Dr. Gerry R. Holden was born in Concord, New Hampshire, September 12, 1874. He received his preliminary education at Phillips Academy, Andover, Mass. He graduated from Yale University in 1897, receiving the degree of Bachelor of Arts. In 1901, he secured his M.D. degree from the Johns Hopkins University.

Following his graduation, he spent six months as a special student in the Universities of Berlin and Brezlau, Germany.

During the years 1902-1903, Dr. Holden served as an interne at the Roosevelt Hospital. New York. In 1904 and 1905, he was assistant and resident gynecologist at Johns Hopkins Hospital and instructor in gynecology for the Johns Hopkins Medical School.

Dr. Holden came to Jacksonville in 1905 with his bride, the former Miss Anne Milliken of Summitt, New Jersey, and went into partnership with Dr. Carev P. Rogers. Their practice was devoted exclusively to surgery and the majority of their work was done in the then DeSoto Sanitarium of Jacksonville, one of the early modern hospitals of Florida. This later became St. Vincent's Hospital. His partnership with Dr. Rogers continued for three years at the end of which it was dissolved and since that time Dr. Holden has practiced as an independent physician.

Dr. Holden was appointed gynecologist for the St. Luke's Hospital, Jacksonville, in 1908, and served in that capacity for twenty years. Since 1928 he has served as consulting gynecologist for that hospital. He also served as gynecologist for the Duval County Hospital, Jacksonville, from 1910 to 1919 and has been consulting gynecologist to that institution since 1925. He has also served as consulting gynecologist to the Florida State Hospital, Chattahoochee, since 1910.

Dr. Holden is a member of the American Medical Association, American College of Surgeons. Southern Surgical Association, Southeastern Surgical Congress and Southern Medical Association.

THE SARASOTA MEETING

The Fifty-Ninth Annual Meeting of the Florida Medical Association, held in Sarasota, May 3 and 4, was a success from every standpoint. The total attendance was 366, there being 282 members, 31 visitors and 53 members of the Woman's Auxiliary.

The local entertaining county society arranged for a delightful round of entertainment throughout the meeting. The scientific sessions were well attended and the papers were of unusual merit. The technical exhibits were well patronized and produced a tidy sum which was used for the purpose of entertainment.

The members of the Sarasota County Medical Society are to be congratulated on their efforts in preparing for this meeting and to them the Association extends its thanks.

LETTER TO GUBERNATORIAL CANDIDATES

As instructed by the Executive Committee, the secretary of the Association and Editor of the Journal recently mailed the following letter to the gubernatorial candidates:

"May 16, 1932.

"At the last annual meeting of the Florida Medical Association, held in Sarasota, the Executive Committee of the Association directed that I, as secretary, write a letter to each of the gubernatorial candidates, asking them to go on record with the Association as to whether or not they would be willing to receive and accept suggestions from the Association in making the following appointments: members of the State Board of Medical Examiners and the State Health Officer.

"It is the desire of the Florida Medical Association to request you, in view of your probable election as Governor, to agree to make the appointments above mentioned from a group of prospective appointees who will be acceptable professionally and personally to the Florida Medical Association. Please specifically understand that the Florida Medical Association is not requesting you to appoint any certain individual, but that you make the appointments from a list of medical men submitted by the Florida Medical Association as a whole. If the initial list does not contain names acceptable to you, additional names will then be submitted.

"During the meeting, it was brought out that in the past, some members of the State Board of Medical Examiners were not acceptable to the Medical Association due entirely to their lack of professional and personal qualifications and it is believed that your administration will be a much more efficient one insofar as the health of the state is concerned, if the above named appointees have the unqualified endorsement of the State Medical Association in that it is the representative medical organization in the state.

"As to the State Health Officer, disastrous results would follow the appointment of one selected purely upon political qualifications. It is manifestly evident that the State Health Officer should be an individual not only thoroughly trained in the matter of medical education but the individual should be one who has special training in medical administration and public health activities generally.

"The Florida Medical Association is composed of a voting strength of approximately seventeen hundred. The Florida Medical Association publishes a Journal and it will, through its columns, advocate the policy of requesting the Governor-elect to cooperate with the Medical Association to the extent above outlined.

"You are, of course, cognizant of the fact that the appointments, with the exception of the appointment of the State Health Officer, are almost entirely honorary and, in a sense, without compensation. You are assured that it is the purpose of the profession, represented by the membership of the Florida Medical Association, to attempt to maintain the high standards for medical licensure and public health actitivies that have thus far been developed under conditions of very great difficulty.

"Thanking you for your response, and with kind personal regards, I am

"Cordially yours,

(Signed) "SHALER RICHARDSON, M.D., "Secretary and Editor."

APPROVED HOSPITALS IN FLORIDA

Compliance with the minimum requirements for standardized hospitals in the state, as recommended by the Hospital and Medical Education Committee, enables a hospital to appear on the approved list of the Association. It is anticipated that this list will be published annually in the Journal of the Association. Any hospital that is approved by the American College of Surgeons will be automatically included in this approved list. There have been very few changes in the following list which was published last year:

LIST OF APPROVED HOSPITALS OF THE FLORIDA MEDICAL ASSOCIATION, INC.

CITY	HOSPITAL	KAHN
1. Century	Turberville	FA
2. Clearwater	Morton F. Plant	FA
	Halifay District	

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	City	HOSPITAL	RATING
4.		.Memorial	
5.		. Alachua County	
6.	Gainesville	. University of Florida Infirmat	ry CA
7.	Jacksonville	Duval County	. FA
8.		Brewster	
9.		Riverside	
10.		St. Luke's	
11.		St. Vincent's	
		U. S. Marine	
		U. S. Veterans	
		Morrell Memorial	
15.	Miami	Dade County	. CA
	Miami	James M. Jackson	. FA
17.		Miami Riverside	
18.		Victoria	
19.		St. Francis	
20.		Monroe Memorial	
21.	Orlando	Fla. Sanitarium & Benevoler	
		Association	
		Orange General	
23.		Pensacola	
24.		.U. S. Naval	
25.		Florida East Coast	
26.		Flagler	
27.	St. Petersburg.	.City Hospital of St. Petersburg	g CA
28.		St. Anthony's	
29.		Florida A. and M. College	
30.		Children's Hospital of Tamp	
31.		Tampa Municipal	
32.	W. Palm Beach	Good Samaritan	. FA
	A-Fully appro		
(CA—Conditional	ly approved.	

SUGGESTIONS REGARDING COUNCILORS

In the past the Council has almost always been a body of great potential strength but of little actual value to the State Association. Anything which it has produced has seemed to be the result of the efforts of individual men, rather than of the body as a whole.

In our Constitution the aims of the Council are wisely put in very general terms but the body is not given any specific objectives for which to work. Probably this lack of objectives is one of the reasons why the Association has not profited as it might have done from the inherent power which, year after year, has laid dormant in these aggregations of loyal and intelligent men.

Dr. Edwards fully realized the possibilities for valuable assistance which lie in this body. He has emphasized them repeatedly before various county meetings and in his Presidential Address. He inaugurated a movement to make this body take the place which it should in the work of our Association. The present administration will endeavor to carry on with this work which he has so well begun.

Actually, the Council can be made a body as important as any of the committees in our organization. In addition to acting as the Board of Censors of the Association, its members form a connecting link between the officers and the component Societies and therefore, indirectly,

between the Association and the lay public in the District in which each councilor serves.

In the expansion of activities which were urged by Dr. Edwards in his Presidential Address, activities which the present administration is pledged to carry out, the Council will be asked to help in some of the following ways:

- (1) To assist the Public Relations Committee in its contacts with the Press of the State by personal interviews with editors of local newspapers. This can be done either by the Councilor personally or delegated to some other member should the Councilor feel that the second man has a better entree to the editor. It is of greatest importance that the Press of the State understand our motives in our press releases. One personal interview with a medical friend whom the editor knows to be sincere, with no axe to grind, will help our Public Relations Committee more than scores of official notices and communications from an impersonal official source.
- (2) Certainly this year the Council can be of invaluable help to the Legislative Committee. Every candidate for office should be interviewed and we trust will be interviewed. Let the Councilor see that each such candidate in his district be interviewed by a personal medical friend and, furthermore, let the councilor see that the interviewing friend knows exactly what he is to say to that candidate. This year every Councilor should actually be an auxiliary member of the Legislative Committee in that he should be ready to act at any time upon any request forwarded him by the Legislative Committee.
- (3) The Councilors should each become thoroughly familiar with the workings of our Association and its office force. Each one should make at least one visit to our business office and personally acquaint himself with the work of that office; learn the methods which are used in transacting the business of the Association; realize the efforts which are being made to safeguard the members of this Association and promote their welfare. They will then be in a position to report to the county societies in their various districts definitely as to these activities.
- (4) These contacts with county societies should be of great value in stimulating interest in the State organization, in holding societies together, and reviving any which may be in a semi-comatose condition.
- (5) In any other way in which the Councilors may be of aid in contacting between the Committees and either the local Societies or lay public they will be called upon when necessary.

In order that the Councilors may be fitted to carry out such duties, the Council must be organized. This is provided for in the Constitution but it has not always been carried out to the letter.

Before any Councilor is appointed, care will be taken to insure that the candidate understands fully the duties of his office and his acceptance will imply his assurance that he will make every effort to faithfully fulfill the duties of his office. After the roster of the Councilors is completed, a meeting will be held at some central point when an organization will be completed and the affairs and duties of the body will be fully discussed.

It is much to be hoped that, working along some such lines, with the welfare of our organization at heart, the Council may assume the position in our organization which is provided for by our Constitution and By-laws.

DOCTORS' GOLF TOURNAMENT SARASOTA MAY 2, 3 and 4, 1932

First prize in the Doctors' tournament was won by Dr. Clarence A. Rudisill of Tampa, who had a handicap of sixteen, and shot a brilliant 80, giving a net score of 64. Dr. Rudisill's name will be engraved on the silver loving cup that was put up by the Orange County Medical Society last year. Dr. L. J. Netto of West Palm Beach had a net score of 71, having shot an 83 with a 12 handicap. He received a Boston bag offered by the Surgical Supply Company of Jacksonville, Tampa, and Miami. Dr. Robert M. Harris of Miami had a low gross score of 78, which with a handicap of six gave him a net 72, for which he will receive a Boston bag offered by A. S. Aloe and Company of St. Louis.

Dr. R. A. Ely of Tampa shot a 92 with a handicap of 20, giving him a net 72 for which he will receive a prize from the Surgical Supply Company of Jacksonville, Tampa and Miami. Dr. J. T. Cowart of Tampa had a net 73 with a handicap of 22, and received four golf balls. Dr. M. A. Nickels of Clearwater had a net 74 with a handicap of 19, and received golf balls. Dr. Walter Jones of Miami, Dr. Joseph Halton of Sarasota, and Dr. H. J. Blackmon of Tampa each had a net score of 75, with handicaps of 16, 17, and 36, respectively, and received three Walter Hagen golf balls each. Dr. J. N. Taylor and Dr. R. R. Duke of Tampa had net scores of 76 with handicaps of 22 and 14, respectively.

Net scores among those who also ran but did not shoot their best score, were included:

Doctors H. J. Peavy, Miami, 77; Tom Hutson, Miami, 77; C. E. Tumlin, Miami, 77; W. M.

Rowlett, Tampa, 77; L. B. Dickerson, Clearwater, 77; G. L. Osincup, Orlando, 77; J. N. Hoffman, Pensacola, 78; Warren Quillian, Miami, 79; L. W. Blake, Bradenton, 79; B. H. Palmer, Miami, 79; M. J. Flipse, Miami, 79; F. D. Gray, Orlando, 79; W. M. Marr, St. Petersburg, 80; J. C. McSwain, DeFuniak Springs, 81; D. C. Cleghorn, Miami, 81; S. Gyland, Brewster, 82; H. M. Taylor, Jacksonville, 83; David R. Kennedy, Sarasota, 84; J. R. Chappell, Orlando, 91.

Dr. Chappell received the prize offered by Mr. and Mrs. Everette Johnston of the Bobby Jones Golf Course at Sarasota, one deck of cards explaining how to play golf at home.

It is suggested that in future tournaments the doctors be very careful in naming their handicaps. Anyone who consistently turns in a handicap which is all out of proportion to his ability and gross score will thereby automatically eliminate himself from participation in these tournaments, which we hope to maintain at a very high standard so that they will continue to be a source of great pleasure to all concerned.

(Signed) DAVID R. KENNEDY, M.D., Chairman, Golf Committee.

STATE NEWS ITEMS

Dr. A. B. Cannon, Lacoochee, president of the Pasco-Hernando-Citrus County Medical Society, is now doing post-graduate work at Tulane University, New Orleans.

* * *

Among the members of the Florida Medical Association to attend the annual meeting of the Alabama Medical Association were: A. M. Ames, C. J. Heinberg, A. R. Haisfield, M. A. Lischkoff, N. M. McLane, J. H. Pierpont, H. L. Simpson and J. S. Turberville, all members of the Escambia County Medical Society

* * *

Dr. Duncan Owens, formerly of Atlanta, Ga., is now associated with Dr. Arthur L. Walters of Miami Beach.

Dr. W. H. Watters of Coconut Grove recently left for Boston, Mass., there to resume his summer practice. Dr. Watters spends each winter in Coconut Grove and each summer in Boston.

Dr. G. C. Tillman, Gainesville, recently attended the Third Annual Meeting of the Southeastern Surgical Congress held at Birmingham, Ala.

Dr. and Mrs. Leroy H. Oetjen of Leesburg announce the birth of a daughter, April 1st.

Drs. W. G. Miles and J. M. Beggs of Chattahoochee were awarded first and second prizes in the Tarpon Tournament, held in Sarasota during the meeting of the Florida Medical Association.

* * *

Dr. Thos. E. Buckman, Jacksonville, was principal speaker at the weekly luncheon of the Lions Club recently. Dr. Buckman has been active in the work of the Duval County Tuberculosis Association and also in the operation of Hope Haven.

DR. EDWARD T. CRANEY

The following resolution was recently passed by the Orange County Medical Society on the death of Dr. Edward T. Craney:

On February 22, 1932, our fellow physician, Dr. Edward Thomas Craney, was called to the great beyond following a brief illness.

Born in Pottsville, Pa., January 3, 1878, he received his preliminary education at Westchester Normal School, Westchester, Pa., and graduated from the Medico-Chirurgical College, Philadelphia, serving his internship at St. Margaret's Hospital, Pittsburg, Pa.

He began the practice of medicine in Pittsburg in 1912, where he remained in that capacity until 1919 when he came to Orlando and shortly thereafter resumed the practice of his profession until his death.

Dr. Craney married Miss Edith Mae Ake June 30, 1913. Mrs. Craney and two daughters Mary, age 17, and Catherine, age 15, survive.

Dr. Craney was conscientious, quiet, and unassuming. He inspired confidence, loyalty, and devoted friendship from those with whom he came in contact.

He was President of the Orange County Medical Society in 1927 and served with credit in that capacity.

Whereas, we the members of the Orange County Medical Society feel deeply the loss of our brother and past president, Dr. Edward Thomas Craney. Therefore, be it

Resolved, that the members of this Society express their sorrow in his passing; that a copy of this resolution be spread upon our minutes as a reminder to us and that copies be sent to his bereaved family and published in the Florida Medical Journal.

(Signed) G. H. Edwards, M.D., Chairman; W. H. Spiers, M.D.

Dr. Gerry R. Holden, president of the Association, recently made a trip down the east coast, visiting newly appointed councillors and representatives of Broward and Dade County Medical Societies. Stewart Thompson, business manager, who also made the trip, contacted the manager of the Hollywood Beach Hotel, starting preliminary arrangements for the 1933 convention.

DR. LOUIS H. VAN ENGELKEN (A RESOLUTION)

Dr. Louis H. Van Engelken died at 5 p. m. on January 9th, 1932, after an illness of two weeks with bronchitis, which had developed complications which caused his death

Dr. Van Engelken was born in Bremen, Germany, 76 years ago. He was the son and grandson of physicians.

His father was an outstanding physician in northern Germany as a mental specialist and maintained a private sanitarium for the treatment of his patients.

Dr. Van Engelken first entered the University of Erlanger, Bavaria, later the famous University of Heidelberg, and then the University of Munich, from which he received his M.D. He practiced medicine first in Germany, then St. Louis, Mo., and 21 years ago moved to Ocala, where he has since lived.

Dr. Van Engelken was a member of the Marion County Medical Society for many years. His hobby was floriculture.

He left a wife (nee Lilly Doderline), born in Munich; a daughter, Mrs. Joseph Rountree, and a granddaughter, Patricia Rountree, all of Ocala; also a son, Fred, living in Canada.

We, the members of the Marion County Medical Society, regret that though he had spent about fifty years of his life in the active practice of medicine that the end must come and we extend to the members of his family, and friends, our sincere sympathy and sorrow and we direct our Secretary to set aside a page in our minutes to record this tribute to our departed fellow-worker. We direct also that a copy of these minutes be presented to his family and to the State Medical Journal.

(Signed) A. H. Freeman, M.D., W. B. Jordan, M.D.

DR. NORMAN M. HEGGIE

As this issue of the JOURNAL is going to press, we learn of the sudden death of Dr. Norman M. Heggie, who succumbed to heart attack on the evening of May 9th. Dr. Heggie practiced his specialty of eye, ear, nose and throat for twenty-six years in Jacksonville and was always prominent in the Association affairs.

COMPONENT COUNTY SOCIETIES

BAY COUNTY MEDICAL SOCIETY

At the call of its vice-president, Dr. L. H. Bartee, a special meeting of the Bay County Medical Society was held on March 20th. At the request of the City Commission of Panama City, this meeting was held for the purpose of recommending a City Health Officer. The precedent set in this case is a step in the right direction by taking the appointment of City Health Officer out of politics, and has met with the approval of the Bay County Medical Society.

(Signed) W. J. Lee. Secretary.

Brevard County Medical Society

The following officers have been elected to serve for the ensuing year:

President—I. M. Hay, Melbourne. Secretary—I. K. Hicks, Melbourne.

DADE COUNTY MEDICAL SOCIETY

The Dade County Medical Society held two meetings during the month of April, the first on April 1st and the second on April 15th. The scientific program of the first meeting related to spinal anesthesia and motion pictures on this subject were shown. At the second meeting, the paper of the evening was presented by Dr. L. A. Hodsdon on the subject: "Tterrigium." The meetings were well attended and very interesting.

ESCAMBIA COUNTY MEDICAL SOCIETY

The Escambia County Medical Society met Tuesday, April 12th, at the U. S. Naval Hospital. The following program was presented:

"Trigeminal Neuralgia, Report of Case", Lieut. F. A. Hughes, (MC), U.S.N.

- "Recent Advances in Aviation Medicine", Lieut. W. E. Kellum, (MC), U.S.N.
- "Rational Treatment of Diabetes", Lieut.-Commander C. M. Smith, (MC), U.S.N.
- "Clinical Analysis of 150 Operations Upon the Gall-Bladder and Biliary Tract", Lieut.-Commander C. M. Shaar, (MC), U.S.N.

MANATEE COUNTY MEDICAL SOCIETY

At a recent meeting of the Manatee County Medical Society, the following officers were elected to serve for 1932:

President—W. D. Sugg, Bradenton.
Vice-President—H. Gates, Bradenton.
Secretary-Treasurer—A. Q. English, Palmetto.

ORANGE COUNTY MEDICAL SOCIETY

The following officers of the Orange County Medical Society are serving for the present year: President—G. S. Osincup, Orlando. Vice-President—Hewitt Johnston, Orlando. Secretary—Louis Orr, Orlando. Treasurer—Chas. J. Collins, Orlando.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. George A. Dame entertained the Society at its March meeting. Dinner was served at the Orange Hotel, and this was followed by a scientific meeting in Dr. Dame's office. Dr. E. G. Peek of Ocala, honored guest, and councilor for the Fifth District, was introduced by Dr. Geo. A. Dame. Dr. Peek brought the Society a very cordial greeting on behalf of the Florida Medical Association, complimented the Society on its work and pledged his cooperation and help as Councilor. Dr. Peek also read a very interesting paper on "Intestinal Obstruction", which was well discussed by the doctors present.

The April meeting of the Pasco-Hernando-Citrus County Medical Society was held at Brooksville. Dr. Geo. R. Creekmore was host to the Society. A course dinner was served, followed by a scientific meeting. A resolution was recommended, urging the federal Government to discontinue its present plan of hospitalization in government institutions for all disabilities incurred by veterans regardless of whether or not such injuries or illnesses were in any way related to service during the war and to provide a system of cash benefits to the veterans who have incurred disabilities since their discharge. Three interesting clinical cases were presented and discussed. Dr. T. F. Jackson of Dade City invited the Society to meet with him in May.

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MRS. ERNEST W. VEAL, Secretary-Treasurer	So. Jacksonville

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Mrs. W. W. Kirk, Finance							. Jacksonville
MRS. J. R. WELLS, Public Re	ela	tion	4	:			Daytona Beach
Mrs. H. Q. Jones, Hygeia							. Ft. Myers
MRS. S. E. DRISKELL, Press	ind	Pu	bli	city			. Jacksonville

The sixth annual meeting of the Woman's Auxiliary to the Medical Association was held in the Christian Church at Sarasota on May 4, 1932, Mrs. S. E. Driskell, president, in the chair.

Following the invocation by Rev. W. A. Harp, the welcome address was given by Mrs. W. J. Johnston, to which Mrs. E. G. Peek of Ocala responded.

The Auxiliary very happily received a lovely bouquet of flowers bearing the card of Dr. G. H. Edwards, Dr. L. M. Anderson and the Florida Medical Association, and was honored by having Dr. G. H. Edwards, president of the State Association; Dr. L. M. Anderson, chairman of the Advisory Committee; Dr. Shaler Richardson, Editor of the Journal, and Dr. Stewart G. Thompson, Business Manager, come into the meeting and express greetings.

Mrs. Walter Jackson Freeman of Philadelphia, president-elect of the American Medical Auxiliary, was introduced as the guest of honor.

Reports showing efficient work were given by all the officers and committee chairmen. The reports made by the county presidents were very interesting and told of much constructive work being done.

One new County Auxiliary was recognized that of Polk County with a charter membership of twenty-seven.

The special program adopted for the coming vear was that of stressing health education, particularly in a public relations capacity.

A most inspirational address was made by Mrs. Walter Jackson Freeman telling of the aims and the possibilities of Auxiliary work.

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The World's Largest Makers of Pharmaceutical and Biological Products The report of the nominating committee was read as follows:

President—Mrs. Leigh F. Robinson, Fort Lauderdale.

President-elect—Mrs. E. G. Peek, Ocala.

Vice-President—Mrs. Arthur L. Walters, Miami Beach.

Secretary-Treasurer—Mrs. E. W. Veal, Jacksonville.

There were no other nominations from the floor and the above officers were unanimously elected.

The gavel, a gift to the Auxiliary by Mrs. J. Ralston Wells of Daytona Beach, was presented to Mrs. Robinson by Mrs. S. E. Driskell, retiring president.

Delegates to the American Medical Auxiliary were elected as follows: Mrs. Arthur L. Walters, Miami Beach; Mrs. H. H. Harris, Jacksonville; Mrs. E. G. Peek, Ocala. Alternates—Mrs. O. O. Feaster, St. Petersburg; Mrs. Rufus Thames, Milton; Mrs. Wilburn Lassiter, Gainesville. Sponsor—Mrs. J. Ralston Wells, Daytona Beach.

There being no further business the meeting adjourned to meet in Hollywood in 1933.

POLK COUNTY ORGANIZED

We are happy to announce that the Polk County Medical Auxiliary was organized April 22nd with a charter membership of twenty-seven. The following officers were elected:

President—Mrs. E. R. McMurray, Bartow. Viee-President—Mrs. John F. Wilson, Jr., Lakeland.

Seeretary-Treasurer—Mrs. V. H. Ragsdale, Ft. Pierce.

Mrs. Herman Watson of Lakeland and Mrs. H. K. Murphy of Mulberry were chosen as delegates to the State meeting. Mrs. Walter Weed of Lakeland is to act as publicity chairman.

In our next Journal we want to tell something of the social part of the meeting at Sarasota and also about Mrs. Freeman's visit to various Auxiliaries in the state.

MEMBERS AND GUESTS REGISTERED AT THE SARASOTA MEETING

Guest of Honor

Mrs. Walter Jackson Freeman, Philadelphia, Pa.

President-elect of Woman's Auxiliary to American

Medical Association.

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Tumlin, Mrs. C. E.	
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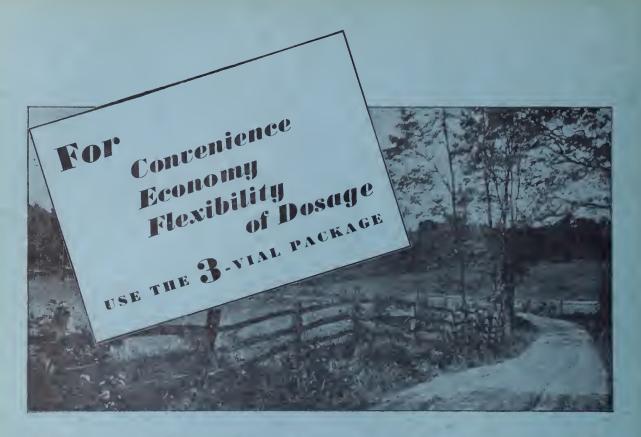
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

			ME	ETINGS		
SOCIETY	SECRETARY	Date	Time	Place	Luncheon?	Dues Paid.
Alachua	J. E. Maines, Jr., M.D., Gainesville.	2nd Tucsday	12:00 Noon	White House	Yes.	
Вау	D. M. Adams, M.D., Panama City.					
Brevard	I. K. Hicks, M.D., Melbourne.	3rd Tuesday		Varies		
Broward	Anna A. Darrow, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall	No.	
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Splcer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardee- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Duval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambla	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
Jackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Les Memorial Hospital	No.	
Leon-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
Madison	Geo. O. Davis, M.D., Madison.					
Manatee	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May; 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando- Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	
Pinellas	Alvin L. Mills, M.D., St. Petersburg	Every other Thurs.	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	
St. Johns	Reddin Britt, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	
St. Lucie-Okeecho- bee-Indian River-Martin	J. D. Parker, M.D., Stuart.	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	J. C. Patterson, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	J. T. Denton, M.D., Sanford.	2nd Friday	8:00 P.M.	City Hospital		
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
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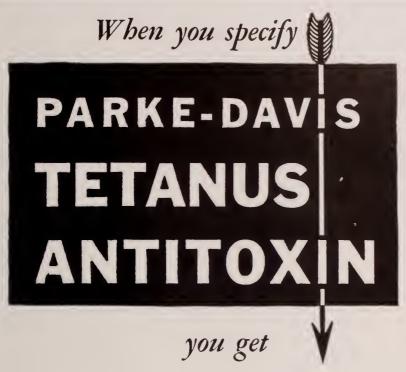
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A PROPOSED COMPENSATION ACT AND ITS RELATION TO THE PHYSICIAN*

S. E. Driskell, M.D., Jacksonville.

In bringing the subject of workmen's compensation before you it is not our desire to give a lot of statistical figures but to stimulate your interest by briefly reviewing a bill we have in mind. relating particularly to the physician.

The adoption of workmen's compensation for industrial injuries in lieu of the rule of the employer's liability for injuries due to his negligence stands out in its effect on the status of the worker as one of the most important legal-economic developments of modern times. A right to relief based on the fact of employment, practically automatic and certain, replaces the doubtful contest of a recovery based on proof of employer's negligence and of the absence of the common law defense.

The first compensation law was that of New York in 1910. Since that time all states except Arkansas, Florida, Mississippi, North and South Carolina have enacted similar laws. What we present is collected from the various state laws and from personal correspondence.

Type of Law: No fixed form of analysis or summary in this outline can give in complete detail the provisions of the act under consideration. It relates not only to compensation of accidents but to accident reporting, safety provisions, the enforcement of safety laws, the establishment of insurance system, premium rates, and the establishing of given amounts to employee as well as payment to physician for services rendered. We feel that the insurance should be handled by some old line reliable company, and settlements with both employee and physician should be made direct, unless an agreement cannot be reached, then jurisdiction should be vested in the Circuit Judge without the necessary expense of legal advice. If this could be done, it would relieve the state of the expense incidental to an insurance commissioner. The necessary blanks could be obtained from some state official vested with such authoritity.

Scope of Coverage: An act of this type should cover the various industries, including state and municipal employees, except perhaps agricultural and domestic and those covered by federal act. The act should be binding on the employer in order to secure the best benefits for employee and physician. Any industry employing less than two would not be affected by this act, unless by written request.

Compensation and Fees Permitted: A definite schedule should be worked out by the proper authorities, taking into consideration the workman's weekly or monthly salary or wages. It should not be less than three dollars per week or more than 65% of said pay. If there are one or more dependents, a given schedule for each dependent should be specified. As to charges permitted by physician, we advise a definite schedule as a part of the act, naming a minimum of three dollars for house visits, one-half of that amount for office calls. Surgical work should be regulated to conform, as nearly as possible, to charges for such work in community where work is done, however, not to exceed two hundred and fifty dollars for a given case. This maximum might be reached in certain types of medical service. A fee greater than the above may not prevail except on the advise and consent of employer and insurance company holding coverage. Hospital and nurse care should be regulated in same manner. All accidents should be reported within twenty-four hours and employee's pay should not begin until the end of the third day, thereby relieving the employer of the necessity of paving for week-end beach parties. Physicians should, however, be paid for any service rendered. This act should provide for report on physical findings to determine nature and extent of injury and probable period of disability. Supplemental report on extent of recovery, whether earning capacity is restored in full or in part, may require services of physician not interested in the case. This will not be necessary unless there is some dissension.

^{*}Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

The rate of compensation allowed or permitted for these special examinations should be as small as practical to secure competent opinions, and should be borne equally by both employer and employee. If this is done it will be much easier to reach an amicable settlement. It is advisable that a panel of physicians be retained by employer for such emergencies as may arise, except, of course, when there is only one physician in a given community. The average state act provides for a fee of only ten dollars. The general rule among various states is that fees for medical attention will not be granted unless such attention is given by or under the supervision of one duly authorized to practice medicine and surgery. Since there is no distinction in our state laws between physicians and osteopaths it appears that some hedging is necessary. The act might state that the doctor of medicine called should be qualified to practice under the act that legalizes medicine. We have one state that permits Christian Scientists to care for injured if employee so elects. Our profession must not permit Florida to give us such classification.

Recently in Jacksonville a laborer sustained a fracture of one of the large bones and was rusined to service ward of one of the local hospitals. It developed he was an employee of one of the biggest corporations in the South. It is true this company is a heavy taxpayer in Duval County, but we believe this company is better prepared to provide medical and hospital care from a pecuniary point than the average physician. No doubt each of you is familiar with similar cases in your respective communities.

In presenting this outline we are not unmindful of present economic conditions, therefore have not discussed the creation of a commission to supervise and handle the business detail of the proposed act. For best results such a commission is necessary and one of its members should be a physician. This could be added later by an amendment.

DISCUSSION

Dr. F. L. Fort, Jacksonville:

Dr. Driskell's paper is a very timely one. Regardless of our wishes in this matter, it seems almost certain that Florida will have some kind of state compensation law in the near future. Some of the forty odd states have laws that are satisfactory to the medical profession, while others are very unsatisfactory.

It seems very difficult to get any amendment

passed to these compensation laws, once they are on the statute books. Several compensation bills have been presented to the Legislature in Florida during the past few years. So far as 1 have been able to learn this association has had no part in the framing of these bills. They may have been very bad or very good so far as you or 1 know. We should be very much interested in this matter. You may rest assured that the insurance companies investigated them. They are organized to protect their own interest, and I do not blame them. But they are not going to exert much effort in behalf of our hospitals or the medical profession. Neither will any one else.

Therefore, it seems to me that this Association should immediately appoint a committee to study the compensation laws of other states and be prepared to advise us and the law-makers of this state what would be just and fair regulation for all parties concerned in this matter. For it appears that the hospitals are more vitally concerned than the medical profession, as they are at present forced to give free treatment to a large number of industrial accident cases, which expense should be borne by industry.

We cannot reach a satisfactory conclusion on this very important matter by open debate here. The medical profession should be better able than anyone else to judge the rights of the injured, the rights of the hospitals and physicians as well as industry as a whole. I hope the president of this Association will appoint a committee to study this complex problem, or that the Legislative committee will do it, and be prepared when the time comes to recommend, or to fight, if necessary, for a compensation law as fair to all as possible. It should be done before the next Legislature meets, because we might be burdened with an odious law which we could never change.

Dr. S. E. Driskell, Jacksonville (Concluding):

I wish to thank Dr. Fort for his discussion. I think he is quite right in stating that some type of compensation act is inevitable. In all probability the next session which will convene early next year, I believe, will enact some kind of law, and my sole object in presenting this outline today was simply to stimulate your thoughts along these lines. I would suggest that you take it up with your representatives and senators and let them know the type of law that you would like to see enacted.

I thank you.

MODERN TREATMENT OF THYRO-TOXICOSIS*

Spencer A. Folsom, M.D., F.A.C.P., Orlando.

PRE-MODERN PERIOD

The Greek and Roman writers made reference to goitre. Pliny made mention of goitre in the Alps, so that the Swiss endemic disease was quite familiar even then. These are the most important references in the ancient literature.

Vesalius (1543), Eustachius (1552) and William Wharton in the Renaissance wrote descriptions of it. Wharton, in a work entitled, "Adenographia," published in London in 1656, is particularly interesting.

The germ of the theory of internal secretion was apparently present in the eighteenth century in the mind of Theophile de Borden, in whose "Analyse Médicinale du Sang," published in 1776, is set forth the doctrine that not every gland but every organ of the body elaborates a specific substance or secretion which passes into the blood stream.

The literature on the thyroid, however, up to and through the eighteenth century, has largely to do with the description of endemic goitre. It was through such enlargement that the thyroid became known in antiquity. The term "bronchocele" is much used for goitre in the older literature, but Heister pointed out that trachocele would be more accurate.

In the English literature of much historic interest are the papers of Prosser, who in 1769 described the "Derby Neck," and Benjamin Mosely, who in 1800 described the "Alpine Bronchocele." In the same year Benjamin S. Barton wrote a memoir on goitre as it prevailed in North America, chiefly among the Oneida Indians of New York.

Undoubtedly, the most enlightened statement at this time is that of Fodéré (1800), who described goitre as an indulent tumor of the thyroid. He mentioned that each little grain of the gland contained a juice which is much increased in engorgement. Stagnation of this humor forms goitre. This idea was not far from the truth. He also pointed out that in the past goitre was confused with scrofula.

DISCOVERY OF EXOPHTHALMIC GOITRE

Of more interest today is the story of the development of knowledge of that peculiar syn-

drome now generally known as exophthalmic goitre in contrast to simple goitre. This syndrome, so striking in its characteristic manifestations, has not been known for centuries.

In the beginning of the nineteenth century we find written accounts of it. In 1802 Giuseppe Flajani of Rome, in his "Collezione d'Osservazioni e Riflessioni di Chirugia," relates the case of a young Spaniard who developed a tumor in his neck accompanied by dyspnea and palpitation of the heart.

A much more complete and clearer description, however, is that of Dr. Caleb Hillier Parry, the distinguished physician who practiced in Bath between 1780 and 1816. His observations are recorded both in his "Elements of Pathology and Therapeutics," published in 1815, and in his collected medical writings published posthumously in 1825. Parry's first case was seen by him in 1786.

The next account is that by Robert J. Graves of Dublin, published first in the "London Medical and Surgical Journal" in 1835, and second, three years later, in his "Clinical Lectures."

The same observations were made independently by von Basedow, a district physician in the small town of Merseburg, Germany, who published in 1840 an excellent account of the syndrome.

The history of exophthalmic goitre may be divided conveniently into three periods. The first, extending from 1802 to 1840, comprising as it does the works of Flajani, Parry, Graves and Basedow, may be called the period of discovery.

The second period which we will now examine is one of further description and rather more interpretation (chiefly erroneous) and in it practically all of the symptoms and signs that we now know were recognized and described by such masters as Trousseau, Marie and Charcot.

The third period is that of the development of the modern theories of the morbid physiology of the disease.

NATURE OF THE THYROID SECRETION

Bauman, in 1896, found that iodine is a normal constituent of the gland. It had been known long before this that the administration of iodine salts often caused a diminution in the size of goitres. Coindet, in 1820, noting that both the marine alga, Fucus vesiculosus, and dried sponge had been successfully used in the treatment of goitre, concluded that the only principal common

^{*}Read before the Fifty-Ninth Annual Meeting of the Florida Medical Association, Sarasota, May 3, 4, 1932.

to these was iodine, and so tried iodine salts and found that they worked.

Regarding the iodine relationship the next important step was Marine's demonstration that iodine is necessary for normal thyroid function and that endemic goitre is to all intents and purposes to be regarded as a deficiency disease, deficiency of iodine. Finally in 1915 came Kendall's great discovery, the isolation from the thyroid in crystalline form of a compound containing sixty per cent iodine and having apparently the full physiological activity of the thyroid gland. In 1917, for this new hormone, called thyroxin, a structural formula was proposed. Thus at last the true function of the gland emerged, namely the production and delivery to the blood of this iodine-bearing autacoid. The modern view of the normal and morbid physiology of the thyroid, therefore, may be said to center about the action of thyroxin on the organism and the factors which control its manufacture.

FURTHER WORK IN TOXIC GOITRE

The third period in the development of knowledge of exophthalmic goitre opened with Moebius' thyrotoxic theory of the disease (1891). He dissociated the disease, as thought by the French writers, to be primarily an affection of the nervous system and showed the true differences between the effect on the organism of the hyper and hypo thyroid.

Frederick Müller (1893) opened the way to an understanding of the role of the thyroid or its hormone in the regulation of metabolism in several of its phases. He clearly demonstrated thyroid hyperplasia and in one of his cases of an increased rate of protein metabolism. He inferred from the paradox of an increased ingestion of food combined with a loss of weight that there must be a metabolic anomaly, an accelerated katabolism in Basedow's disease.

Müller's view was confirmed abundantly by Magnus-Levy, who showed beyond doubt that total katabolism, as measured by the gas exchange, is increased over normal not only in exophthalmic goitre, but also in normal persons on the ingestion of thyroid gland. A little later he showed that the converse is true in myxedema.

Very recently Aub and collaborators, at the Massachusetts General Hospital, have demonstrated an increased rate of calcium and phosphorus metabolism in thyrotoxicosis, and a decrease in myxedema.

Plummer in 1913 helped greatly in the under-

standing of the clinical types of thyroid disorder, one being true hyperplasia with thyrotoxicosis, that is to say, exophthalmic goitre, the other hyperthyroidism resulting from adenomatous tumors of the thyroid gland.

Again in 1923 Plummer demonstrated that iodine in large doses had a specific detoxifying action.

FUNCTION OF THE THYROID

The thyroid gland is evidently not essential for life, since many species are without it and others may still live after its removal. Marine has well said, "Broadly defined, our present conception of the function of the thyroid is that it provides the means, through its iodine-containing hormone, of maintaining a higher level of metabolism than would otherwise obtain and also through fluctuations in its activity it provides a means for varying the rate of metabolism to meet changing physiological needs." It is understood then that the only function of the thyroid is the manufacture of thyroxin; and the action of thyroxin is probably, as Plummer claimed, that of a catalytic agent accelerating metabolism in all cells of the body.

Plummer and Boothby estimate that the total amount of active thyroxin in the body is from twelve to fourteen milligrams. The catalytic power of the thyroxin, in terms of energy, has been estimated by Boothby and Sandiford to be about one thousand extra calories for every milligram of the hormone.

Thyroxin is undoubtedly elaborated in the parenchymal cells of the thyroid, and probably reaches the blood stream through both lymphatics and veins. The parenchymal cells of the thyroid secrete colloid also. The purpose colloid serves is not well understood.

Kendall concludes that thyroxin affects metabolism through its action on hydrogen. It has an important influence over the distribution of body water, tissue colloids and electrolytes.

Thyroxin has a fundamental action exerted on the nervous system. Cerebral activity in its absence falls to a low level, and the irritability of the nervous system is much reduced. This is seen typically in myxedema; the reverse is true in hyperthyroidism.

The effect of the hormone upon peristalsis is striking, and probably exerted through the nervous system. It can be studied well by means of information regarding the bowel movement of patients. In myxedema there is constipation

while in the hyper condition there is often diarrhea.

In the adult mammal, then, an adequate supply of thyroxin is necessary for normal energy exchange, salt metabolism, water, electrolyte and colloid distribution, and for a normal action of the nervous system and the organs under its control; in the growing individual it is necessary for growth as well. Its apparent relationship of action to the ovaries and anterior pituitary gland as well as to other glands of internal secretion can not be gone into here.

CLASSIFICATION OF THYROID DISORDERS

Any classification of any disease that is simple is the best classification. Simplicity is the key note to the intelligent understanding of a condition and its clinical application. A simple classification is as follows:

- 1—Diffuse colloid goitre. {endemic. }sporadic.
- 2—Adenomatous goitre. \ with normal function. \ with hyper function.
- 3—Exophthalmic goitre.
- 4—Cretinism. Sendemic.
- 5-Myxedema.
- 6—Cachexia strumipriva.
- 7—Thyroiditis.
- 8—Malignant tumors of the thyroid.

BASAL METABOLISM DETERMINATIONS

The function of the gland can now be studied very accurately. The index of this function is the basal metabolism. If we are correct in assuming that the primary, probably the only, function of the thyroid is the production of thyroxin, and if the major action of this hormone is that of a catalyst accelerating cellular oxidation, it then follows that the measurement of the rate of oxidation in the body as a whole is an index of the supply of thyroxin, and hence of the functional activity of the thyroid.

Relative to basal metabolism we can conclude that:

- 1—Basal metabolism can be studied readily in an office or hospital clinic with comparatively inexpensive apparatus.
- 2—The normal basal metabolism is a fairly constant affair, the approximate range of normal being plus ten or minus ten.
- 3—A marked rise occurs in hyperthyroidism.
- 4—A marked fall occurs in hypothyroidism.
- 5—Relative to hyperthyroidism, basal meta-

- bolism furnishes one of the best means we have of following the course and judging the effectiveness of treatment.
- 6—The basal metabolism is a good index of the severity of toxic goitre, but if taken alone may be misleading.

The thyroid chart demonstrating the progress of a case should consist in metabolism, pulse and body weight estimations. Rates of basal metabolism should be used in judging of the effectiveness of treatment and in the differential diagnosis of obscure pictures. If always duly subordinated and correlated with the clinical data, they may be properly so employed. Dubois has well said, "God forbid that we make our diagnosis by machinery." Nevertheless, if we make the machine servant of our clinical judgment it can render important aid.

We must not assume that thyroid activity solely determines metabolic rate. We find increased metabolism in leukemia and in fevers, sometimes in pernicious anemia and hyperpituitarism, and we find certain persons with low rates who show no clinical evidence of hypothyroidism.

In the evaluation of our metabolism data we must preserve an open mind. An increased rate in an afebrile patient usually denotes thyrotoxicosis if leukemia is ruled out, and if we are sure the rate obtained was truly basal: that is to say, if the patient had not recently had food, had remained at complete rest, and was not suffering from acute emotion.

DIAGNOSIS

We can not treat disease unless we can diag nose it. We can not diagnose a condition unless we think of it. To think of it we must know symptoms and know them well. The diagnosis of the thyrotoxicosis in its fully developed form is perhaps one of the easiest in the whole field of medicine. Note that we say in its fully developed form. The difficulty of diagnosis lies often in the fact that the disease is not fully developed or may be masked or apathetic as so well discussed recently by Levine and Lahey.

In a typical case is often found the famous Merseburg triad; goitre, exophthalmos, tachycardia and Marie's fourth sign, tremor. The simple hyperthyroid symptoms are those directly or indirectly due to increased metabolism and the resulting increased circulation and respiration, namely, those due to increased heat loss, increased sweating, peripheral dilatation, flushed warm skin, sensation of warmth; those due to increased

destruction of tissue, loss of weight, and compensation, increased appetite; those dependent on increased circulation, palpitation, dyspnea, tachycardia, increased pulse pressure, and violent heart action with apparent enlargement of the heart and systolic murmurs; and finally those due to a mild increase in the irritability of the central nervous system.

The eye signs are the protruding globe of Parry, Graves and Basedow, the wide fissure of Stellwag, the lid lag of von Gräfe, the poor convergence of Moebius and the infrequent winking of Dalrymple. Any or all of these signs may be present, and in some true cases none may be. Neither the significance nor the manner of causation of these eye signs individually or collectively is known.

The other symptoms are the extreme restlessness amounting to almost ceaseless motion and mental excitation. Myasthenia, as stressed by Plummer, is also a characteristic feature, and in examining patients he notes especially the performance of the act of climbing upon a chair or table.

A number of other manifestations occur occasionally, for example, diarrhea and amenorrhea. Slight fever is occasionally present when the intoxication is marked, and high temperatures may be met in a toxic crisis. The increase in pulse rate and blood pressure closely, but not exactly, parallels the rate of metabolism. The blood often shows a relative lymphocytosis, the so-called Kocher blood picture. The reaction to adrenalin is increased and Goetsch has used this fact as a diagnostic criterion. Sugar tolerance is decreased and the vital capacity of the lungs has been found by Rabinowitch to show a reduction which closely parallels the rise in metabolism.

The cardiac type of masked or apathetic hyperthyroidism will prove a stumbling block in diagnosis unless it is more thoroughly understood and searched for. These patients come to the physician complaining of various symptoms such as angina pectoris, palpitation, dyspnea, weakness and dyspnea, Adams-Stokes Syndrome, etc. Unless the basic cause is recognized they suffer increasing circulatory disability and may eventually die of cardiac failure.

It must therefore be quite clear that these cases are to be looked for anew, with somewhat different criteria than those to which we have been accustomed and are not to be confused with the ordinary cases of hyperthyroidism which now show cardiac complications. Remember that the ordinary signs and symptoms of exophthalmic goitre are missing and that the cardiac picture predominates. One of the most common cardiac signs is periods of transient auricular fibrillation. There is no other condition in which this occurs so frequently and it would be well to suspect hyperthyroidism in any patient who shows this disturbance, no matter what other disease may already exist.

Another characteristic of the heart that should make one suspect hyperthyroidism is failure to obtain slowing of the ventricular rate in a case of auricular fibrillation after proper digitalis administration. In the ordinary case, unless there is fever, the heart-rate slows to between sixty and eighty on full doses of digitalis. When hyperthyroidism exists, although such slowing occasionally occurs, more commonly it is impossible to obtain a rate under one hundred.

A further finding is the persistence of a regular heart rate of over ninety at rest in bed, in the absence of fever. Most ordinary heart patients with a regular rhythm will show a rate of cighty or under after a few days' observation in bed, even if there is decompensation. Of course, many functional heart patients will have a slight tachycardia even in bed, but then, if the heart is counted while the patient is asleep, it will be found to slow, whereas a tachycardia is apt to persist in hyperthyroidism.

DIFFERENTIAL DIAGNOSIS

Exophthalmic goitre must be differentiated from other forms of thyroid disease, colloid and adenomatous goitre and from the functional diseases of the nervous system. Some cardiac neuroses, chronic febrile states, particularly tuberculosis, and leukemia may imitate it. The neuroses should offer no particular difficulty in diagnosis, it usually being possible to obtain ultimately a basal reading within ten percent of the standard figure.

MEDICAL ASPECTS OF THYROTOXICOSIS

The general practitioner and the internist possess a strategic position relative to the ultimate results to be obtained in the treatment of this disorder. It is to them in many instances, in fact most instances, that the patient comes for an opinion and advice. They must literally be on their toes and make a diagnosis as soon as pos-

sible, place the patient on a proper plan of preliminary treatment and then refer the case to a radiologist or surgeon with whom they should work in close harmony.

When the diagnosis is definitely made the case should be placed at perfect, or as near perfect as possible, mental and physical rest. All stimulants of any type should be eliminated as well as any demonstrable foci of infection.

A diet sufficiently high in calories to make the patient gain weight should be instituted. The protein should also be high (1.5 to 2 gm. per kilogram of body weight) because of the rapid breakdown of protein in this disease. Fluids should also be high and average three thousand to thirty-five hundred cc. in the twenty-four hours.

Every one should have it clear in his mind that there is no actual medical treatment of the condition if we think in terms of a cure. Therefore, the administration of iodine is merely a temporary palliation of symptoms in preparation for actual treatment, either radiological or surgical.

I believe that there is too much iodine used indiscriminately before and after a diagnosis is made. Iodine is valuable when used correctly, but is a two-edged sword when used incorrectly.

It is generally agreed that iodine, by reducing the intensity of the disease, has diminished the risk of operation. It has been claimed recently, however, that the reduction in mortality caused by iodine is often over-estimated and statistics at the Mayo Clinic, Crile's, Lahev's, Porter's. Richter's, Riedl's, Crotti's, Eiselsberg's and Dunhill's compared to both the pre and post-iodine eras bear this out. Bevan states that the average mortality for this country at present is between three and five per cent. In interpreting such data it must, of course, be borne in mind that a thyroid operation before the days of iodine was usually less extensive than now and that some patients who previously would have died before operative interference was possible, are now operated upon.

Iodine, however, in the form of Lugol's solution, when given in a dosage from five to ten drops three times a day an indeterminate number of days, will cause a drop in the basal rate and amelioration of symptoms. Then, determined by the extent of the drop and the general condition of the patient, operative interference should be done, in from one to two weeks, except in the more severe cases.

When patients are refractory to iodine, shown by an initial drop of the basal rate and later rise, the disease flourishes in a severe form. These refractory cases usually happen when the administration of iodine has been prolonged. Jackson has noted that "the greatest risks (operative) occur when patients have been given iodine for many months until they develop a tolerance to it." In such patients "the same reaction after operation is expected as before iodine was used."

Refractoriness appears to occur primarily in moderately severe and severe cases rather than in mild cases. Omission of iodine for a period of about four weeks will cause most patients to lose their refractoriness to it and again show a marked response.

It should be emphasized that the pre- and postoperative administration of iodine has not completely abolished post-operative reactions. It has merely reduced their number and intensity.

We feel justified in saying then that the control of iodine over the disease is relative and not absolute, and that after it has been administered for a long time, its beneficial effects may disappear entirely. Every detail of the pre-operative and post-operative period should be managed carefully with close cooperation between the medical man and surgeon. The treatment of the condition is much more than the administration of iodine, the operation of subtotal thyroidectomy, or radiological exposure.

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DISCUSSION

Dr. John E. Boyd, Jacksonville:

I am sorry that Dr. Folsom did not devote more of his allotted time toward a discussion of his very fascinating subject, "The Modern Treatment of Thyrotoxicosis."

Thyrotoxicosis is defined by the latest medical dictionary as a diseased condition produced by poisons which enter the system through the thyroid gland or by excessive activity of the gland. Whatever, then, is to be done in the way of treat-

ment must be directed against either or both of those occurrences. So far it has been attempted to do this by medical measures, by treatment with the roentgen rays, and by the surgical removal of a part of the gland—sub-total thyroidectomy. As far as I know, neither the medical nor the roentgen treatment has yielded particularly satisfactory permanent results. At the present time surgery seems to have accomplished more for these unfortunates than any of the other measures tried, and even that has its percentage of disappointments.

I am convinced from my own study of the literature and a somewhat wide personal experience that the surgical results are based not so much on the type of operation done, nor the individual technique used, but mainly on how much of the gland is removed, and what provision is taken against post-operative laryngeal complication and tracheal obstruction. The simplest way I know of to provide against tracheal obstruction is to be sure and remove the isthmus, leaving the anterior portion of your trachea free. I find that the surgeon who operates these cases only occasionally is very apt to leave too much gland. Control of the goitre cases at the Duval County Hospital has converted me to Crile's contention that a sufficient amount of gland should be removed to produce a hypothyroidism that will persist for at least one year. Naturally, you ask "how much gland is that?" Frankly, I don't know how to tell you, and I doubt if Crile himself could. Certainly it is necessary to remove the largest part of the gland, and since I have been forcing myself to remove more than I felt was really safe, my results have been very much bet-

In conclusion, I want to caution you against discharging your goitre case as cured because the pulse rate subsides to a normal rate before the patient is discharged from the hospital. If you will institute a careful follow-up of these cases, you will find that many of those so discharged will report to your office with a rate of 80 to 100, more often the latter. A careful supervision of their diet and their rest for a period of months usually results in correcting this. In the meantime you should take care to caution your patient against undertaking any strenuous duties, either mental or physical. If this regime fails to bring about the desired result within a reasonable length of time, then you should advise your patient to have a removal of further gland tissue. I would very much rather correct my own errors than have somebody else accuse me of ciminal negligence. Only once, so far, have I been forced to feed a post-operative case thyroxin. But, too often have I had to advise a patient that he or she required further surgery. And these cases have by no means been confined to the other man's patients.

Dr. J. B. Parramore, Jacksonville:

I hesitate to come before you and offer a plan of treatment, though it seems to me that some one should mention it. In my humble opinion a great many of these mild thyroid cases are the result of infection. From clinical observation I am of the opinion that diseased tonsils, diseased sinuses and diseased teeth are responsible for a large number of such cases.

About three years ago I had a young lady patient who had symptoms of an enlarged thyroid. She had badly diseased tonsils, so I advised their removal. She did not consent to this, and in about ten days she had a peritonsillar abscess. Within two days there was a marked enlargement of the right lobe of the thyroid. I had Dr. Frederick Bowen in consultation. After she recovered from her acute attack we decided to see what effect removing the tonsils would have on the case. A short time after I removed her tonsils she was markedly benefited.

Now, I am not trying to say that all cases should have the tonsils removed. But I do think that all patients in the early stages should have the tonsils, teeth and sinuses investigated, and if they are diseased this source of infection should be removed.

Dr. Harold O. Brown, Tampa:

I think that in thyrotoxicosis we perhaps pass over a little too lightly the possibilities and advantages of X-ray treatment. I don't believe that X-ray can be looked upon as replacing surgery at all, but frequently it can be used with benefit to the patient in preparing him or her for surgery.

However, there are certain types of goitre that should not be given X-ray. Colloid and simple adenomatous goitres do not respond, but exophthalmic and toxic adenomas do respond very nicely. The malignant goitre of course is a proper case for X-ray treatment.

There has been some claim that X-ray treatment handicaps the surgeon. That is not the case when X-ray is properly applied. There is no

reason why surgery should not be just as easy after a course of X-ray as before.

As regards the X-ray treatment: We don't have accidents. We don't have a loss of voice. The patients are not subjected to the shock of operative interference, and when the X-ray is properly applied and the patient is properly prepared for X-ray, there is no shock resulting to the patient. Recurrences following X-ray treatment are no more frequent than they are following surgery.

Of course, in any treatment, it is necessary to clear up focal infection. It is also very important at times to rest the patient up before therapy. Often it is necessary to hospitalize the patient. Great care should be given in the first treatment of these cases. The patient comes in nervous and oftentimes the basal metabolism will rise materially just from the thoughts of treatment. However, with proper assurance to the patient, these cases can be handled very satisfactorily.

Dr. Spencer A. Folsom, Orlando (Concluding):

I wish to thank the doctors for their kind discussion of my humble presentation of this most important subject. I brought up the subject of radiologic exposure hoping that I would get an argument between the X-ray man and the surgeon. That was my primary object in mentioning it.

As far as the subject is concerned I am still interested in the one phase of it which I think most vital—that is, of course, the obscure case. Any one can diagnose a fully developed one. Therefore, these heart cases with fast rates after days of rest in bed, and these heart cases that present auricular fibrillation not controlled by digitalis are potential hyperthyroids until it is proven that they are not. We should bear this in mind.

As far as foci of infection are concerned, I fully agree with Dr. Parramore in his discussion of my paper. That is another point that we should bear in mind, to try to rule out every demonstrable focus before any real treatment is instituted.

I repeat, there is no such thing as medical treatment in these cases, but is more aptly termed medical management. The surgeon really does the treatment. The others just work in cooperation with him and help to attend to those details which are so necessary to the successful termination of the case.

PRE-ADOLESCENT TORSION OF UTERINE ADNEXA WITH REPORT OF A CASE*

W. C. Payne, M.D., Pensacola.

In view of the fact that torsion of the uterine adnexa in the pre-adolescent age is a relatively rare condition, we feel justified in presenting a case.

CASE REPORT

K. F., age seven, had always been a delicate child and was rather small for her age. About two years prior to her present illness, she began having attacks of lower right abdominal pains. These attacks came on rather suddenly and radiated down the right thigh and were accompanied by nausea and vomiting. The first attacks were mild and lasted only a few hours. During these attacks, she was attended at various times by some of the most competent physicians in three of our neighboring cities. None of them, I believe, reached a positive diagnosis but all suspected the possibility of acute appendicitis. The first attack in which I saw her was in July, 1930. The symptoms at this time were fairly mild and passed off in a few hours. She complained of pains in the right lower abdomen radiating to the right thigh and accompanied by a mild degree of nausea. On the 10th of November following, I saw her in a similar but more severe attack. At this time she had a temperature of 99% F. and a leucocyte count of 19,000 with 80 per cent neutrophiles. There was no rigidity of the abdominal muscles but a distinct tenderness on deep pressure over McBurney's point. We felt justified in making a diagnosis of acute appendicitis and advised operation. I made the following notation on her operative sheet: "Appendix found congested, moderately indurated and free from adhesions. It was rather large and extended down toward the pelvic cavity. The tip was particularly hard and contained some foreign body." The pathological report was acute appendicitis.

I quote the above to show why I made no further abdominal explorations. I felt satisfied that the condition of the appendix was sufficient to account for her symptoms and since she was only seven years old, it never occurred to me to make a pelvic examination. Her recovery was uneventful and she remained well for $2\frac{1}{2}$ months.

^{*}Read before the Escambia County Medical Society, March 8, 1932.

On January 24, 1931, she again had an attack of right lower abdominal pain. The onset was sudden and accompanied by extreme nausea. The nausea during the first twenty-four hours was the most pronounced symptom. On the following day the nausea was somewhat less pronounced but the pains were more severe and at times extended up toward the right lumbar region to such an extent as to suggest the possibility of kidney colic. There was considerable abdominal distention. We were unable to get a good bowel movement. The result of repeated enemata was very unsatisfactory. The temperature which was 991/2 the first day, rose to 100 F. on the second day and the leucocyte count rose to 20,000 with 84 per cent neutrophiles. The patient presented a picture of severe illness. Dr. G. C. Kilpatrick saw her with me and we felt justified in advising an exploratory laboratory without a diagnosis. The most probable diagnosis in our minds was intestinal obstruction. At operation a very dark mass was found in the pelvis which on first inspection gave one the impression of a gangrenous volvulus. The mass was the size of a lemon and practically filled the pelvic cavity. There were fresh adhesions between the mass and all the adjacent viscera. There was considerable distention of the entire intestinal tract and the coils in contact with the mass were congested. The mass was easily lifted out of the pelvic cavity and was found to be a torsion of the right tube and ovary. The interesting point to me was the small pedicle. The pedicle was not more than half the size of a lead pencil, so that all that was needed to remove the mass was to ligate the pedicle with a strand of catgut. We were unable to determine either the direction or the degree of rotation of the pedicle. Microscopically, the tube and ovary were completely infarcted and no microscopic details were discernible.

The case to me was so interesting that I decided to review the literature on the subject. Fortunately for me, however, my attention was called shortly afterward to an article by Dr. Robert Kent Finley of Dayton, Ohio, which appeared in the March, 1931, number of the Journal of Surgery, Gynecology and Obstetrics. This is a most comprehensive study of the literature on the preadolescent ovarian torsion and in my subsequent remarks, I take the liberty of quoting freely from Dr. Finley. Finley found that Smith and Butler had reviewed the literature from 1900 to 1921 and found reports of twenty-five cases and added

one of their own. He then reviewed the literature from 1921 to 1931 and found twenty-five additional cases reported and added one himself. His case was one of cyst of the right ovary with torsion of the pedicle. The pedicle consisted of the Fallopian tube with part of the broad ligament. By means of lipiodol injected into the uterine cavity and Fallopian tubes, he was able to make a correct pre-operative diagnosis. A review of his collected case reports shows that a correct pre-operative diagnosis was seldom made. The pre-operative diagnoses were:

Appendicitis	. 9
Some pathological condition of the bowel.	. 4
Some surgical condition of the adnexa	. 3
Encysted fluid in the abdomen	. 1
Suspected torsion of an ovarian cyst pedicle	e 1
Ovarian tumor	. 1





Two views of the Gross specimen

ETIOLOGY

The causes of torsion of uterine adnexa may be divided into predisposing and exciting. The predisposing causes fall under two headings: (a) —histological, (b)—anatomical or mechanical. The histological causes would include tumors and cysts of the ovary. The mechanical or anatomical would include a long mesovarium and unusually long tube or a large ovary which pulls upon its attachment sufficiently to form a pedicle. Auvray believes that the spiral course of the tube normal in fetal life might persist in extrauterine life and be a predisposing cause. I wish here to quote the following paragraph from Finley regarding the exciting causes. "Among other factors which may enter into the development of torsion, Kohler quotes Selheim as saying that the inertia from a uniform twisting motion of the body may be transmitted to a tumor and cause it to undergo torsion on its pedicle. This is most apt to occur to a mass which is freely movable, its surfaces smooth, and its contents fluid. Torres reports a case of torsion probably caused by a fall from a chair. Anspach mentions the effect of some sudden unusual exertion, such

as lifting or straining at stool, which probably increases intra-abdominal pressure, thus rotating the tumor. Peters finds that during a coughing spasm, the small intestines are thrown down into the lower abdomen suddenly and with considerable force. If an ovarian tumor should be present, the impact of the intestinal mass against the tumor would be a factor in producing torsion. Other writers suggest a sudden decrease in the pressure as the emptying of an overdistended bladder, and in the adult the emptying of a gravid uterus, as being a factor in producing torsion.

"Payr offers hemodynamic theory. He experimentally induced torsion in different organs by increasing their venous pressure. He showed that if the veins of a pedicle become engorged, torsion may go on without any other additional force. It is well known that veins of pedicles are longer than arteries associated with them, and that their walls are thinner, and stretch easier than do the more muscular walls of the arteries. A slight pressure on a pedicle insufficient to interfere with the lumen of the artery may be sufficient to compress the veins, bring about their dilatation and elongation, and cause them to describe a spiral around the more fixed parts of the pedicle, namely, the connective tissue and the artery. Such spiral turns of the veins may, according to Payr, carry the cyst, if not too large, around the pedicle and bring about torsion."

It is not logical to believe that unless there is a predisposing cause that any of the phenomena listed under exciting causes would be sufficient to produce torsion. In the cases I have reported, I believe the predisposition was congenital. There was no evidence of a tumor or cyst of the ovary and I cannot imagine any force which would have separated the tube from its attachment to the broad ligament if it had ever been normally attached to it.

DISCUSSION

Dr. J. M. Hoffman, Pensacola:

I had the pleasure of assisting Dr. Payne when this patient was operated upon. I concur with him in the opinion that a congenital anomaly must have been present, to have produced this condition with such a small pedicle. It could not be definitely determined that a torsion had taken place. Microscopically, the individual tissue could not be differentiated, being entirely engaged with blood. No necrosis had taken place, demonstrating that the circulatory disturbance was venous, rather than arterial. The question of a

venous thrombosis may be considered, but the lack of inflammatory pathologic evidence, and the clinical course and history would preclude that possibility. The presence of an ovarian cyst could not be determined, either on gross or microscopic examination.

The presentation of this case report should call our attention to the possibility of the occurrence of this condition in the young girl, and warn us to explore the pelvic viscera, in the young female on laparotomy, particularly where no other definite pathology is found.

Uterosalpingography surely offers us a means of diagnosis of these conditions that should be used oftener, as outlined by Finley in the excellent article mentioned by Dr. Payne in his paper.

CHOLECYSTITIS IN THE ADOLES-CENT; CASE REPORT*

S. WARD FLEMING, M.D., West Palm Beach.

In 1923, Kellogg¹ collected 64 cases reported in the literature of gall-bladder disease occurring in children through the age of fifteen years. J. A. Beals² tabulated sixty additional cases in the Southern Medical Journal of August, 1928, with a very comprehensive review of the literature. In the discussion of Beals' report, Dr. Evarts A. Graham emphasized the fact that cholecystitis is not nearly so rare in childhood as we ordinarily think it is. In the St. Louis Children's Hospital during the past ten years, there have been eight cases diagnosed as cholecystitis occurring between the ages of $1\frac{1}{2}$ and 15 years.³ In the case reported below, attacks of indigestion and dyspepsia and right-sided abdominal pain have been present since the age of twelve years.

Miss F. J., age 15, white, entered Good Samaritan Hospital on June 18, 1928, with the chief complaint of pain in the upper abdomen, nausea and vomiting. There were no serious illnesses recorded in her past history with the exception of similar attacks during the preceding three years. The previous attacks, though not so severe, were associated with considerable pain and tenderness in the right abdomen. The present illness started with epigastric pain and nausea about two days before admission. The symptoms partially subsided but became much more severe following a heavy meal. No urinary disturbance, bowels constipated.

^{*}Read before Palm Beach County Medical Society, August, 1931.

Physical Examination. — Temperature 100.8 pulse, 106, respiration 26. Abdominal respiratory movement restricted. The abdomen tense throughout, but increased rigidity present on right extending around to lumbar region. Point of greatest localized tenderness at lower border of right upper quadrant, but also marked tenderness Right knee held constantly flexed. Rectal examination negative for pelvic disease; white blood corpuscles 14,000; catheterized urine negative for pus.

In view of history, examination, negative urinalysis, leucocytosis, a diagnosis made of an acute abdominal condition, most probably a highly placed appendix lying lateral to the cecum; and as a second possibility, an acute inflammation of the gall-bladder.

Operative Note.—High right rectus incision made and exploration showed a greatly enlarged, thickened, acutely inflamed gall-bladder lying between the colon and the lateral abdominal wall. Gall-bladder freed of numerous adhesions and removed intact. Appendix small, not inflamed and not removed because of additional risk. Rubber dam drain, closure in layers. Pathological examination of gall-bladder showed acute purulent cholecystitis with an area of beginning necrosis at fundus. No stones present.

Post-Operative Course.—Satisfactory, practically normal pulse and temperature on the third day. Small amount of biliary drainage noted on the twelfth to fourteenth days. Discharged on the twentieth day. Patient rapidly resumed active life following operation. Excellent health was reported by questionnaire three years afterward. Diet has been unselected. Swimming and diving contests caused no disability.

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RUPTURED (RARER TYPE) ECTOPIC GESTATION WITH A REVIEW OF THE LITERATURE AND A

> CASE REPORT CAROL C. WEBB, M.D.,

> > Pensacola.

In approaching the rarer type of ectopic gestation of this article it becomes necessary to consider it in its entirety. Therefore, to define, suffice to say that when the fertilized ovum embeds itself and starts to develop in any position outside the cavity of the uterus, ectopic pregnancy exists, and this term includes a pregnancy in the interstitial portion of the tube.

The first case to be recorded of this condition was made by Albucasis, an Arabian physician, in the eleventh century, when he described that portions of a foctus were working from an abscess of the abdominal cavity through its wall. During the seventeenth century, more cases were recorded and more descriptions in detail and varieties were given.

For many years it was considered one of the rarest of accidents to which woman was susceptible, but since the successful operation upon this condition by Lawson Tait of Birmingham, England, in March of 1883, there have been reports of cases abounding in the literature. Some idea of the number can be had from the fact that Formad of Philadelphia found thirty-five ectopic gestations in thirty-five hundred autopsies of women and Cragin of New York City, in one series of pelvic surgery numbering five hundred cases, reports thirty-eight ectopics.

In 1752, Böhmer adopted the classification which is accepted today of tubal, ovarian and abdominal. Wynne, Farrar and others made the following discoveries as to incidence: sixty to seventy per cent of the women afflicted were between twenty-five and thirty-five years of age; it was perhaps slightly more common in the negress; twelve per cent occurred in the first conception; the average number of normal conceptions and pregnancies was two or three although the average length of time elapsed since the last pregnancy was about three and one-half years; it may occur while mothers are nursing their babes or it most commonly occurs after a prolonged period of sterility.

The case I desire to report is that of Mrs. J. O., age twenty-two years, white, usually energetic but never robust, who was employed as stenographer and bookkeeper. Her chief complaint was repeated attacks of fainting which started shortly after arising one morning and continued on her way to work, gradually getting more exaggerated and frequent, until she was forced to return home at about the noon hour. When she called me to see her, at about one o'clock, she was swooning frequently and was advised to go at once to the hospital. She waited until four o'clock to be admitted when her symptoms were quite alarming. She was admitted with her only complaint, "faintness."

Her family history was above question and no heredity elicited in reference to systemic disease. Her past history was irrelevant as to her present condition; her menses had been regular since their onset at the age of puberty, and she was at this time about three or four days past her regular menstrual time.

Her physical examination revealed apparently normal eyes, ears, nose, throat, thyroid; her lungs showed no dull area on percussion and only normal vesicular breathing was heard on auscultation. Her heart was fast but no murmur or arrhythmia was elicited; her reflexes were normal, and the upper and lower extremities were normal. Her skin was pale, dry and exsanguination was evident; she had had removed about four weeks previous the right lower third molar which was still draining pus from the cavity, and several small sequestra of bone had come from the wound. Her abdomen was scaphoid; no rigidity nor pain was elicited, except in the left lower quadrant which was not commensurate with her appearance. Her temperature was only slightly subnormal; vaginally there was tenderness in the lower left side of the pelvis and a soft tumor mass was felt in the cul-de-sac. Her urine was normal and the bowels had moved repeatedly with enemas during the day when many undigested pecans were passed in each stool. Her blood picture was hemoglobin (Talquist), 70; erythrocytes, 2,220,000; total leukocytes 22,250 with the differential of poly-morpho nuclear leucocytes 98% and small lymphocytes 2%.

Immediate operation was advised with ectopic pregnancy the pre-operative diagnosis and a midrectus incision made. The pelvis was filled with free and clotted blood which was removed from the abdominal cavity and the left ovary was found to have a perforated opening from its cortex and was actively hemorrhaging. It was removed and the appendix, which was chronically involved, was removed while the abdomen was being dried and cleaned of clots. Then closing was made with two Penrose drains inserted and five hundred cubic centimeters of normal saline given intravenously. She made a normal and uneventful convalescence, being back at her work in ninety days, having regained her weight and feeling quite normal.

Apparently, a pregnancy in the ovary is the rarest form of ectopic gestation and up to the present time there have been less than fifty cases reported. The following requirements must be met before a diagnosis of ovarian pregnancy can

be substantiated: first, the tube on the affected side must be intact; second, the fetal sac must occupy the position of the ovary; third, it must be connected with the uterus by the utero-ovarian ligament, and fourth, definite ovarian tissue must be found in the sac wall.

The above recited case fulfills all of the requirements for an ovarian ectopic gestation. Dr. J. M. Hoffman, pathologist for the Pensacola Hospital, demonstrated tissue changes of pregnancy within the substance of the ovary in microscopical section; while grossly the ovary was only slightly larger than normal and the perforation opened into the pregnant recess pocket from which the marked hemorrhage arose.

In conclusion, I wish to say that this report has been made only because of its rarety and not because of any unusual surgical procedure necessarily involved in the removal of this ovary.

FOOTBALL INJURIES* GEORGE C. TILLMAN, M.D., Gainesville.

Football to the college man is as the sport of kings to the monarch. It is the major sport of major sports and the varsity is the goal of every college athlete. The sport demands and obtains the very best type of manhood in our colleges and the outstanding football player is always an outstanding college athlete in every particular.

The football player is a super-athlete. A star baseball player, a tennis star, a leader in basketball, need not be a super-athlete, but we seldom see a football man who does not excel in other college sports. In fact, he is usually a three or four letter man.

Football is a game of youth and requires all that youth has to offer: enthusiasm, strength and mental concentration, as well as the desire and will to accomplish an end in every play without regard for self-discomfort or any thought of future disability. The kindergarten of football is the sand-lot and the public school grounds, with a further period of education for the more fit in high school football teams under the supervision of a coach. The outstanding athlete of high school teams later appears on the college gridiron as a candidate for varsity honors, and there he comes in contact with an expert coaching staff who develop and train him into the super-athlete that is able to undergo punishment and exposure to injury that would be sufficient to maim or even kill the ordinary individual.

^{*}Read before the Riverside Hospital Staff, Jacksonville, December 22, 1931.

Football coaching of today has attained the place of a very high ranking specialty, and rightly it is entitled to this position. The usual individual's conception of a football coach is of one who drives men into the fray after instructing them in the maneuvers of modern football and that the training of an athlete is merely a supervised living with a large amount of exercise for the individual. Instead, we find coaches to be, first, expert psychologists, second, possessed of a thorough knowledge of football and, third, able to impart this knowledge and to instill the proper fighting qualities into their teams. In the knowledge of football they are not only experts in the game but also have a thorough knowledge of the physical welfare of the men. Considerable of the training time is directed in instruction in self-protection, as without a team well-trained in this art it would be almost impossible to complete a single game. In this connection, it is interesting to note that of the deaths occurring during the past season only a very small number, four, occurred in welltrained teams and of these one was a substitute player; the remainder were of poorly trained or untrained players. Injuries and accidents do occur in the well-trained team but many of these can be traced to the fact that the individual himself is responsible as in the stress and strain of the play the brains do not function well in certain individuals. The best of instruction may be forgotten for the time being and an injury sustained. This no doubt accounts for many injuries; in fact, for almost all except those sustained in mass play where men fall upon each other, or at times when there is a desire on the part of someone to handicap an individual by injury.

The expectancy of injury among players diminishes with each year of a man's football career. For example, the fourth year man will seldom sustain a seasonal injury or even a temporary one while they are rather frequent in the first year man. The decrease in injuries is also to a large measure due to the study of appliances for body protection which has given us improved kidney, shoulder and collar pads, as well as the improved cushion type head-gear which has almost eliminated head injuries. Another example of the effectiveness of proper padding is the fact that the famous charley-horse injury is almost extinct.

Injuries may be classified as to the degree of incapacity—seasonal, temporary (one or two games), and trivial. The seasonal injury is usually a fracture or a recurrent joint injury and is fortunately rare. The temporary injury is a ligament or soft tissue injury and is more common.

The trivial injuries are many and include lacerations, strains, etc. Injuries to the nose are not seen very often since the nose guard has been discarded.

During the football season of the present year, out of Florida's varsity of approximately forty men, fifteen players failed to participate in one or more games, each due to injuries. One seasonal injury was sustained, a dislocation of the femur. The temporary injuries included three fractured clavicles, one fractured tibia, and one sprained ankle which was treated on the outside by immobilization and resulted in a seasonal handicap, sixteen strains, twelve sprains and abrasions too numerous to mention.

It is remarkable how readily injuries in trained athletes respond to treatment. An injury that ordinarily would totally incapacitate an individual will in these young men frequently give only temporary discomfort and allow them to return to the game in a short time. This of course does not include fractures or severe joint injuries. Another important factor in the rapidity of recovery is no doubt due to the fire and enthusiasm of vouth which stimulates them with the desire to get back into play as early as possible and they exert every possible means to hasten recovery even though it causes discomfort. Owing to the physical development and the excellent physical condition, healing of injuries is rapid and convalescence is shortened. Of prime importance is the need to keep the individual in training, and to avoid the actual loss of muscle strength in uninjured parts so that he may be in proper shape after the injury has recovered to resume his former activity without a period of enforced idleness due to loss of his former muscle strength. It is also a problem to keep all cases ambulatory, if possible, in order that their class room work does not fall below the requirements of the college and thereby prevent them from further play.

In order to properly classify injuries and to prescribe proper treatment, the X-ray is indispensible as is also an experience in handling this type of injuries. On the staff of the institution there must be a well-trained man who is given the title of trainer. This individual must be an expert in massage and should have a knowledge of anatomy rather than be of the usual type which is frequently an ex-prize fighter without any particular qualifications. The trainer must be under the control of the team physician and all treatments must be prescribed by the physician.

Probably the injuries which concern the football player to the greatest extent and determine his future usefulness are soft tissue injuries. I wish to especially stress two of these injuries which are most common and important, and in which proper diagnosis and treatment play an important part. These are strains and sprains.

It is customary to use the words "strain" and "sprain" somewhat indiscriminately. A "strain" is used to denote injury to muscle alone, and the word "sprain" to denote injury to the structures of a joint as well as to its muscles.

A strain, therefore, may be defined as the state of a muscle, the tissues of which have been damaged as the result of the contraction of the muscle not having been powerful enough to resist the stretching effect at the moment of its application. The damage is done, not by the muscle overcontracting to resist the force, but by the force overcoming the power of the particular muscle when it is contracted to its fullest extent. The result is a rupture of multiple or individual fibres, the connective tissue framework, the muscle sheath or its attachments. This type of injury is most frequent and with improper treatment results in a loss of tone of the muscle which, if not regained promptly, begins to waste rapidly and results in a laxity of the joint structure, even after a slight strain. The condition results in a joint which the individual considers "weak." He has a feeling of slight insecurity; the joint is neglected and injury recurs regularly when it is used. Eventually this results in an injury to the joint structures due to the atrophy and unequal support given to the joint by the muscles. In the case of the knee joint, it is apparent as an undue motility of the joint and is the forerunner of cartilage injury. The athlete with this condition always gives a history of a primary injury, usually in high school, and is treated by strapping with adhesive plaster, walking on crutches for a few days and going into practice to work out the joint. From this cause alone, many promising athletes are totally lost to college football while we feel that with proper treatment at the time of the primary injury they would recover and reach us without the handicap.

A sprain is an involvement of any of the joint structures and in addition the muscles are always strained. These joint structures are the bones; cartilage; protecting capsule lining the ends of the bones; ligaments; arteries, veins and nerves; areolar tissue which forms cushions, fills in the various spaces of the joint and carries the vascular pads of fat; muscles and parts of muscles which are bound together by connective tissue (and if all of these tissues are considered in their relation to each other it is readily realized that when they

are damaged the result may be as serious as a fracture or dislocation especially in regard to the end result.)

When a joint injury is sustained there is always effusion into the area and recovery depends on the rate and completeness of its absorption. It is due to this fact that adhesions occur and frequently, if improperly cared for by prolonged rest, result in future disability and even loss of muscle tone and the wasting of muscle as well as the impairment of the synovial membrane.

To prevent, so far as possible, bleeding into the joint we believe it essential to an early and complete recovery that, immediately after an injury, a tight bandage be applied to the injured part before swelling occurs. The patient is then transported to the hospital for examination including an X-ray of the area. The bandage is removed and ice bags applied to the part which is elevated on pillows. After twenty-four to forty-eight hours, depending on severity of the injury, the ice is discontinued and graduated muscle contractions are begun. The flexors and extensors are contracted and relaxed, starting with very slight movements which are intended to move the joint in all directions and continued from fifteen minutes to one-half hour. These are repeated several times daily. The patient does not attempt any movement but endeavors to keep the part absolutely relaxed during the treatment. These treatments are repeated several times daily and rapidly the muscle tone is increased, the pain diminishes and movements become painless and the patient voluntarily performs movements of the part due to the feeling of security. Muscle wasting is prevented, the joint rapidly returning to normal. In certain injuries—for example, fractures—enforced rest of the part is necessary for a longer period but by early movements, such as described, adhesions are prevented and the convalescence is shortened.

We do not advocate plaster of Paris casts but at times it becomes necessary, in order to get these cases ambulatory with safety, to mold a plaster splint to the part. This is dispensed with as early as possible, especially in a cooperative patient who discards the old theory that the part must be worked out in order to hasten recovery.

After four or five days these parts are immersed in the hot whirlpool bath for a period of from one-half hour to one hour with the temperature of the water gradually being increased. At the same time, voluntary movements of the joints are made under the supervision of the trainer.

Injuries treated in this manner are allowed to

resume light practice as soon as can be done without causing actual pain or swelling of the part but the injured part is supported by proper appliances to prevent any stretching of the healing structure.

Prior to a game, all players are strapped with adhesive plaster or special appliances with a view of protecting that particular man from any recurrence of a former injury.

MEETING OF THE FLORIDA DERMATO-LOGICAL ASSOCIATION

Chairman Elmo D. French Secretary J. F. Wilson

The regular quarterly meeting of the Florida Dermatological Association was held in Miami, February 7th. The following case reports were presented:

EPITHELIOMA (Superficial, Rodent Ulcer Type) (Presented by Dr. Elmo D. French)

A. E. D., male, age 49, born in England. First noted what he termed a "Florida" sore on the forehead above the right eye, eight years ago.

The lesion is atrophic with glistening surface. In places, especially that part involving the orbital ridge and upper eyelid, the tissues are fixed to



A. E. D., Case No. 1 (French)

the underlying fascia. The eyelid is retracted. The border is polycyclic, of thread-like elevation and pearly appearance.

(Biopsy: reported later, "I agree that it is a rodent ulcer of the hair matrix type"—Francis P. McCarthy, M.D., Boston, Mass.)

DISCUSSION

Dr. J. F. Wilson, Jacksonville: Lupus vulgaris should be considered. There are active nodules simulating the "apple jelly" type in the lesion together with atrophic scarring.

Dr. W. J. Young, Louisville, Kentucky (by invitation): I concur in the diagnosis of epithelioma because of the slightly indurated rolling border with atrophy in the center. Lupus vulgaris does not have this slight induration and smooth scarring. This is the serpiginous rare type of epithelioma which heals as the lesion progresses with activity at the advancing border.

The question of treatment is equally difficult of decision.

The lesion is adherent to the periosteum toward the centre and above the orbit and X-ray or radium treatment is not promising.

Dr. T. O. Otto, Miami (by invitation): Surgically, the lesion might be excised well outside the advancing margin down to the periosteum, the denuded site treated with Roentgen rays and a full thickness immediate transfer graft utilized.

Dr. W. J. Young (by invitation): By applying X-ray or radium with the idea of destroying the proliferating cellular growth, would you not also defeat the plastic repair because of the necessary effect on normal structure, especially vascular supply?

Dr. T. O. Otto (by invitation): We would "pepper box" the bone plate inducing healthy granulations from the bony structures before applying the graft.

Dr. J. L. Kirby-Smith, Jacksonville: This case would preferably have been shown as a case for diagnosis and for suggestions as to treatment.

Treatment entirely depends upon the diagnosis.

The method of healing in the upper part of the lesion has the appearance of the rodent ulcer type of epithelioma. Follicular inflammatory areas in the central region show no healing process but are active. Sarcoid or lupus vulgaris or other tuberculous process should be considered.

Lupus vulgaris begins in the young as a rule and furthermore I do not believe lupus vulgaris will originate in Florida.

Arrest the disease, if possible, and follow this



Miss A.P., Case No. 2 (French), Fig. No. 1.

by a plastic operation otherwise no operation can benefit him.

EPITHELIOMA (Result of Treatment) (Presented by Dr. Elmo D. French)

Miss A. P., aged 48 years. About ten years ago the condition, exhibited in the photograph, began as a slowly spreading sore on the nose.

August, 1931, under local anesthesia, we destroyed the growth with the high frequency current and cross-fired the denuded tissues with the X-rays.

The object in presenting this case is to illustrate the rarely curative effect of X-ray when the cartilages are involved in an epithelioma and the ability of the large gland follicles in the central portion of the face to renew epithelium.

DISCUSSION

Dr. W. J. Young (by invitation): This is one of the best results I have ever observed.

While considerable time has elapsed since her treatment, the healed area should be inspected every two months.

Usually, I prefer surgery when the cartillages have become involved as in this case.



Miss A. P., Case No. 2 (French), Fig. No. 2. Treatment: High Frequency and X-ray.

EPIDERMOLYSIS BULLOSA HEREDITARIA (Presented by Dr. Elmo D. French)

R. C. A., male, seven months old. Presents painless erosions in the mouth, a milium eruption on the nose and cheeks and about the mouth, ruptured vesicles on the hands and feet with grouped patches of milia.

Two older children are living and well, ages 3 years and 5 years.

One sister, aged 6 years, died suddenly Jan. 8, 1932, and had been seen in this clinic with the diagnosis of epidermolysis bullosa of the atrophic type. (Photograph on exhibit).

DISCUSSION

Dr. J. L. Kirby-Smith, Jacksonville: I concur in the diagnosis. The bullous eruptions, as epidermolysis, pemphigus, dermatitis herpetiformis and certain of the erythema multiforme group are often due to disturbances of the nervous system, reflex, or organic.

In 1912 I reported a case of bulbous dermatitis, cited in Stelwagon's text, i. e., dermatitis herpetiformis, which was permanently cured by circumcision.

Dr. E. D. French: In line with Dr. Kirby-Smith's remarks, McGlasson and Keiler described vacuolar degenerative changes in the spinal ganglia and posterior horn cells in a case dying of pemphigus.

HERPES SIMPLEX

(Presented by Dr. Elmo D. French)

Mrs. H. P., a housewife, aged 64 years, presents a healing grouped vesiculo-crusting lesion of the lips and a circinate pigmented, coin-sized, patch with pinhead sized crusts on the lateral surface of the right thigh. The lesions have recurred in the same localities over a period of three years. There is a history of joint pains.

Further examination reveals a left tonsil, inflamed and exuding pus.

The case is presented as an example of recurrent herpes from focal infection.

DISCUSSION

Dr. J. L. Kirby-Smith, Jacksonville: The process in herpes local is simple, the cause is complicated. It may occur concurrently with menstruation and on the lips after exposure to sunlight. Recurrent herpes of the penis is not cured by circumcision.

Dr. J. F. Wilson, Jacksonville: A case of mine recently seen by Dr. French, with a concurrent herpes of the lips and prepuce was also said to have evidence of nose and throat pathology.

This case several years ago was advised circumcision because of phimosis and persistently recurring herpes of the prepuse. Circumcision was performed with a prompt recurrence in the line of circumcision.

Dr. Rothwell Lefholz (by invitation): Why should we expect circumcision to stop recurrence of herpes progenitalis?

VINCENT'S INFECTION

(Presented by Dr. Elmo D. French)

Mrs. M. T., aged 48 years, housewife, has had painful erosions of the margin and ventral surface of the tongue and the gingivo buccal margins for a period of months. Vincent's organisms were found in abundance.

DISCUSSION

Dr. C. A. Andrews, Tampa: The diagnosis of Vincent's infection often is only the diagnosis of a complicating condition and most often confused with syphilis.

Dr. W. J. Young, Louisville (by invitation): These cases are sent by the Louisville City Hospital to the skin clinic for management and we have had a large experience in their treatment.

Often the superficially ulcerative type becomes very progressive and destructive.

The ulcerative destructive type is hard to differentiate from syphilis. Clinically, Vincent's infection is more painful.

We must remember that fusiform bacilli are present in the normal mouth. The action of arsphenamine is both tonic and specific.

Secondary syphilis, late syphilis, malignancy and diphtheria are to be differentiated.

Dr. J. L. Kirby-Smith, Jacksonville: The diagnosis of Vincent's is too popular. Many of these mouth lesions are purely due to irritative substances introduced into the mouth.

Dr. G. N. MacDonell (by invitation): I have seen diphtheria and Vincent's organisms present in abundance in the same laboratory specimen and especially in the destructive type of lesion is diphtheria to be eliminated.

Other cases presented by Dr. French included: keratosis pilaris; onychomycosis; a treated case of universal psoriasis in a boy nine years old who had remained free of manifestations of the disease for a period of four months; early elephantiasis dura with a pituitary syndrome; a case for diagnosis of a generalized papular eruption with intense pruritis in a negro male adult.

CAROTINOID PIGMENTATION

(Presented, by invitation, by Dr. Rothwell Lefholz)

Mrs. J. F. J., aged 48 years, noticed a yellow discoloration of palms and medial surface of the forearms two years ago. She was treated for jaundice at a nationally advertised food sanatorium without relief.

Clinical examination revealed a canary-colored pigmentation involving the palms, soles, tongue and hard palate; the sclera was not pigmented. No pruritis nor other skin symptoms were present.

Gastrointestinal examination was negative.

Van den Bergh test was negative. Urinalysis did not reveal bile pigment.

Tests for carotin pigment in the blood was positive.

A history of daily consuming papayas, a fruit rich in carotin, was obtained.

RHINOPLASTY—By Pedicle Flap Graft (Case presented by Dr. Thomas O. Otto, by invitation)

Mrs. E. B., white female, age 37, presented herself to the Jackson Memorial Hospital surgical service September 20, 1930.



Mrs. E. B., Case No. 6 (Otto), Fig. No. 1.

Complaint: Pain over nasal region and both ears.

History: Eleven years prior to admission, at the age of 26, patient suffered with chronic skin dosage unknown) twice a week for one year. duration, this condition was treated by X-ray (doseage unknown) twice a week for one year. This was followed by ultraviolet ray treatment for a period of two years. Once during the course of X-ray treatments, the condition seemed to entirely disappear. For the past three and one-half or four years, the entire region on midportion of the nose has been ulcerated, painful and weeping.

Physical Examination: Marked contracture over cheeks at the superior border of large butterfly wing-shaped areas of X-ray burn with characteristic glistening avascular and pigmentary blotching. The entire anterior surface of the nose, from the level of the ala cartillages, upward to the glabellum, was ulcerated, with total destruction of the integument, with areas of involved periosteum and perichondrium exposed. (See photographs Nos. 1 and 2).



Mrs. E. B., Case No. 6 (Otto), Fig. No. 2.

Radical excision of the involved area on the nose, with relaxation of the cheeks, followed by rhinoplasty was recommended. Due to the marked pigmentary and atrophic changes surrounding the X-ray dermititis, pedicle flap graft from thorax was advised in lieu of the classical rhinoplasty, with elevation of the flap from the forehead.

Operative Procedure: Parallel, curved incision, underlying right breast were made and the elevated area between these parallel incisions undermined full thickness and tubularized. Twenty-one days later, partial excision of flap was begun at lateral end of pedicle. This was completed in three weeks.

Dermatological Consultation (Dr. Elmo D. French) was held on Dec. 15, 1930, and a diagnosis of lupus erythematosis (discoid type), with X-ray pigmentary and atrophic changes was made, with a probable diagnosis that carcinoma of prickle-cell type was present on the bridge of the nose.

Biopsy was made from this area and a diagnosis of "fibrous tissue with lymphatic infiltra-

tion, and obliterative endarteritic changes was given by Dr. Joseph Matthieu, resident pathologist of the Jackson Memorial Hospital, Miami. For economic reasons, patient left the hospital and returned February 10, 1931. Division of pedicle flap from lateral border of chest wall was completed February 11th. Left hand, between index finger and thumb, was opened above the thenar eminence and distal end of flap, inserted and sutured in place. Capillary anastamosis was sufficient in three weeks to allow division of pedicle from chest wall. March 25th, radical excision of involved area on nose was done with scarification of periosteum and perichondrium to promote the growth of healthy granulations. May 12th, after application of plaster jacket and aeroplane splint, a pattern of the denuded area was cut out on the flap growing from the left hand and inserted on the nose. Three weeks later, partial division of the pedicle, two inches from its insertion in left hand was begun, and continued until June 6th, 1931, when complete division was accomplished, and the lower border of the scar at the alae of the nose was mobilized and the edges approximated to the distal border

of the newly inserted flap. Since rhinoplasty was completed June 6, 1931, marked relaxation of the face has been obtained. Healing has been maintained and the patient has remained symptom-free. (For results, see Photographs Nos. 3 and 4). Since these photographs, large pigmented areas on the cheeks have been removed by frequent partial excision of elliptical-shaped areas, after the method of Dr. John Staige Davis, of Baltimore, Md. Healing per primum has been obtained each time.

DISCUSSION

Dr. J. L. Kirby-Smith, Jacksonville: This is an unusual result obtained by capable surgery. Usually the plastic repair of X-ray damage to the tissues breaks down.

Dr. W. J. Young, Louisville, Ky. (by invitation): I wish to congratulate Dr. Otto on the splendid results obtained. Because of atrophypresent, and the progressive nature of lupus erythematosis, I would keep the pedicle now growing from the left hand for future use.

Malignant degeneration may vet occur.



Mrs. E. B., Case No. 6, (Otto), Fig. No. 3.



Mrs. E. B., Case No. 6, (Otto), Fig. No. 4.

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EIGHTEENTH DISTRICT-JOSEPH HALTON, M.D Sarasota Manatee, Sarasota.
NINETEENTH DISTRICT-HENRY P. Bevis, M.D Arcadia DeSoto, Hardee, Highlands.
TWENTIETH DISTRICT-WILLIAM R. WARREN, M.D Key West Monroe.
TWENTY-FIRST DISTRICT-H. D. CLARK, M.D Ft. Pierce St. Lucie, Okeechobee, Indian River, Martin.

LEGAL ADVISORS

The State Association at its last meeting authorized the Executive Committee is retain the services of a legal firm of high standing to act in an advisory, legal capacity to our Association and its component and associated societies. In accordance with this action, the firm of Marks, Marks, Holt, Gray and Yates of Jacksonville have been retained.

The services to be rendered by this firm are confined to legal advice, given at their offices and does not include prosecution of cases or other extraordinary services. Any society desiring to avail itself of the services of our attorneys should address its request to the business office of the Association, Box 81, and not to the attorneys directly.

MALPRACTICE INSURANCE

The necessity for malpractice insurance is probably greater today than at any previous period in the history of our organization. Due, probably, to the general financial stringency, suits against physicians for alleged malpractice are becoming more prevalent. Insurance against them and their results is as important for the physician as fire insurance or life insurance.

Since November, 1930, membership in the Florida Medical Association has carried with it the opportunity for each member to obtain high class malpractice insurance at the lowest possible rates by taking out a certificate under our state group policy. Although many of our members have availed themselves of this privilege, there still remains a large body of men who either carry no insurance at all or who are not members of our state group. Membership in this state group not only will give these men satisfactory protection at the lowest cost but will also extend to the men in small county societies, the memberships of which are too small to have separate county groups, the opportunity of participating in this privilege.

The financial saving to the men in the county societies of small membership is far greater than to the members of county societies with memberships large enough to form separate county groups.

The following table indicates the cost of the state group malpractice insurance as compared with the lowest premiums obtainable for county group and individual policies; also the percentage of premium saved in each type of policy:

Amount of Insurance	State Group Premium	County Group Premium	Percentage of Saving	Individual Policy Premium	Percentage of Saving
\$ 5,000 / 15,000	\$17.50 21.35 23.27 24.85 25.73 29.22	\$17.50 23.33 26.25 28.53 29.75 35.00	8% 11% 13% 14% 17%	\$25.00 33.33 37.50 40.75 42.50 50.00	36% 38% 39% 39% 42%

For members using X-ray or radium, or both, for treatment, the above premiums will be increased 100%; members using X-ray for diagnosis only will not incur any additional premium charge.

Members employing assistant physicians, surgeons, dentists, anesthetists, X-ray or radium

technicians will be charged 50% additional of above rates for coverage on such assistants.

As a specific example from the table above, let us consider the policy which gives \$10,000 protection in any one case with a total of \$30,000 in one year, the third item in the table. Under the state group, the premium on this would be \$21.35. If a county membership was large enough for the society to have a group, the premium for this insurance under such a group would be \$23.33. If an individual doctor, who is not eligible to a county group, took out this policy, it would cost him \$33.33. The state group policy would save the doctor in this last instance, \$11.98 in the cost of his insurance—more than his annual state dues.

For these reasons, it would seem most desirable for our membership to cooperate in the large state group, provided that it gives as good insurance as can be obtained by individual policies.

The United States Fidelity and Guaranty Company, which writes our policy, is one of the strongest companies writing malpractice insurance. The policy itself is as good as can be obtained. We quote from a letter signed by Mr. Sam R. Marks of Jacksonville, a member of the firm which is now our legal advisors, under date of June 3, 1932:

"We have examined the master policy now held by your Association and are of the opinion that it affords as broad a coverage as you can reasonably expect."

Mr. Lyman M. Beckes of Orlando, an attorney with wide experience in insurance matters, in May, 1931, gave us the following statement about our policy:

"I have had occasions to construe policies covering physicians, surgeons and hospitals on numerous occasions heretofore and believe that the group form professional liability policy which I have just examined is about as broad a coverage as it has been my lot to examine."

There is a question in the minds of some men as to whether or not a group policy is as good as an individual policy. As a matter of fact, the group policy is the better policy in that the responsibility of the company is not limited to one person as in single, individual policies, but is, to a certain extent, extended to a large group of individuals.

The question has arisen whether or not legally one member of such a group could be prevented from testifying in the trial of another member of the same group. In this connection, we quote from the letter of Mr. Beckes above mentioned:

"I examined the policy with the purpose in mind of determining whether by the terms of the policy one member of the Florida Medical Association could be estopped from testifying for or against another member of the Association. I find there is nothing whatsoever in the policy that will in any way bind a member of the Association to testify on behalf of a fellow member or prevent him from doing so."

The Florida Medical Association is not selling insurance but it does feel that in this group policy it is providing its members with an opportunity which they should not overlook. It is greatly to be hoped that in the coming year more men will avail themselves of it. The names and addresses of local agents of the company which writes this policy can be obtained at any time by writing our Association, Box 81, Jacksonville.

FINANCIAL AID TO SOCIETIES

At the Sarasota meeting, the State Association voted to extend financial aid to county societies in their efforts to rid the state of unlicensed practitioners. The manner in which this financial aid is to be given was very explicitly stated. In order that the funds of our Association may be conserved, it is absolutely necessary that any county society wishing to avail itself of this privilege shall follow the rules which have been adopted.

The following is the procedure which must be used in all cases:

The State Association match dollar for dollar, cash deposited by component County Societies with the State Association's treasurer, this cash to be used for medico-legal activities in said counties. The total amount put up in any one year shall not exceed 50% of the total State dues paid in by that Society during the year and in cash shall not exceed \$200.00 for any one year.

Each request for such financial aid shall be considered by the Executive Committee and no request shall be granted unless authorized by unanimous consent of the Executive Committee. Money received from any component society shall be set up in the State Association books, with a like amount of the Association's funds, to the credit of that County Society. This fund is to be under the jurisdiction of the Association's Executive Committee and no obligations are to

be incurred against this fund without such obligations first being approved by the Executive Committee. Invoices of bills for such approved expenditures shall be filed with the business manager of the Association, covering items of authorized expenditures, and the Association's check shall be issued in payment thereof. No payment for expenditures can be made except by means of the State Association's check bearing the signature of the treasurer of the Association.

This matter is very important and these rules must be observed if county societies are to receive such financial aid.

STATE NEWS ITEMS

At the semi-annual meeting of the Florida Radiological Society, (organized November 14, 1931), which was held at Sarasota, May 2nd, the following officers were elected:

President—O. O. Feaster, St. Petersburg, Vice-President — Frederick K. Herpel, West Palm Beach.

Sec'y-Treasurer-W. M. Shaw, Jacksonville.

* * *

Dr. L. M. Anderson of Lake City, who is the chairman of the Committee on Scientific Work, was a visitor in Jacksonville recently. He called at the office of the secretary and business manager, and also visited Dr. Jelks, formulating plans for an early meeting of his Committee. Dr. Anderson made his attendance at the Rotary luncheon while in Jacksonville.

* * *

A. D. Hinman, who claimed to be a "healer" was recently convicted in the Criminal Court of Orange County for practicing medicine in that county without a license. He pleaded guilty and received a thirteen months' sentence. Dr. G. H. Edwards and Dr. H. W. Gwynn, with the cooperation of the sheriff's office were instrumental in the arrest and conviction of A. D. Hinman.

* * *

Letters have been received from Ex-Governor Martin, Mr. Sholtz and Mr. Howey in reply to the letters sent out to all gubernatorial candidates. Each one of these gentlemen assures us that he is willing to accede to our request as outlined in our letters.

Dr. F. S. Jennings of St. Petersburg left recently for Dryden, N. Y., where he will remain for the summer.

* * *

Dr. Gaston Day of Jacksonville announces the removal of his office from 409 St. James Building to 310 W. Church Street. Dr. Day's practice is limited to anesthesia.

* * *

Dr. J. Ralston Wells of Daytona Beach won first prize for catching the largest king fish during the special tournament for the Florida Medical Association convention held in Sarasota. Dr. Wells received, as first prize, two No. 4 Drone baits, donated by L. B. Huntington of Baltimore, Md.

* * *

Dr. F. F. Kumm of St. Petersburg recently moved to Minneapolis where he expects to locate and take up the practice of medicine.

* * *

Dr. Spencer A. Folsom of Orlando left for Pittsburgh, Pennsylvania, recently where he expects to spend six weeks studying cardiology.

* * *

The State Board of Health takes pride in announcing the organization of the third and largest full time health unit in Florida. On February 8th, the Board of Commissioners of Escambia County took the final action which made it possible for the City-County Health Department to start functioning on March 1st. The Pensacola city council had previously taken the necessary action. With the exception of the Director, Dr. W. A. McPhaul, formerly City-County Health Officer of Charlotte, N. C., the personnel of the unit was recruited locally. There are nine persons in the unit: the director, county nurse, county sanitary officer, dairy and meat inspector, city nurse, three city sanitary officers and clerk.

The cooperation between the unit and the citycounty physician, who devotes his entire time to his official duties, is very close and mutually helpful and already the results of the new set-up are making themselves felt in the community.

As in the case of the other units, the State Board of Health and the U. S. Public Health Service contribute to the budget and the State Board of Health supervises the unit's activities.

The wise counsel and helpful cooperation of the Escambia County Medical Society were of valuable assistance in the organization of the unit. The Florida Medical Association was well represented at the annual meeting of the American Medical Association, which was held in New Orleans, May 10th to 13th. Fifty-eight members of our Association registered during the meeting, as follows:

0,	
Agos, I. H.	Miami
Allen, Bundy	
Baltzell, N. A	Marianna
Barge, H. A.	
Bieker, Annette M.	
Blackmar, R. W.	
Cannon, A. B.	
Change D. A.	Lacoochee
Chapman, B. A.	Jacksonville
Clay, B. S.	W. Palm Beach
Costa, Frank J.	
Darrow, Anna A	
Etheredge, S. H	Tampa
Feaster, O. O.	St. Petersburg
Fellows, J. H	Pensacola
Fraser, Donald S.	
French, Elmo D	
Grable, J. S.	
Grace, Wm. H.	
Graves, J. Raymond	M:-mi
Graves, J. Raymond	D
Haisfield, A. R.	Pensacola
Hanson, Henry	Jacksonville
Harris, Herrman H.	Jacksonville
Helms, John S., Jr	Tampa
Hodsdon, B. F	Miami
Holloway, Luther W	Jacksonville
Ingram, L. C	Orlando
Jenson, H. J.	Tampa
Jones, H. Quillian	Ft. Myers
Knowlton, R. H.	St. Petersburg
Langley, Francis H	St Petersburg
Lischkoff, M. A	Pensacola
McRae, E. H.	Tampa
Maines, John E., Jr.	Gaineswille
Manie I -11- W	Gainesville
Martin, Leldon W	
Morrow, Frank R	
Morton, A. O	Sarasota
Morton, Rosalie Slaughter	Winter Park
Nixon, J. M.	
Panettiere, Cayetano	
Papot, Grace E	W. Palm Beach
Patterson, Wm	Tampa
Payne, W. C	Pensacola
Raap, Gerard	Miami
Repass, Robt. E.	Miami Beach
Rudolph, Councill C	St. Petersburg
Simpson, W. T.	Winter Haven
Spengler, N. L.	Tampa
Sullivay, Rosa L	Pensacola
Summit, R. E	Fustis
Taylor, H. Marshall	Tacksopuille
Timboulake Cidean	St Dotorokura
Timberlake, Gideon	or. Petersburg
Tinkler, B. R.	Lake Wales
Turberville, J. S.	Century
Walters, A. L.	Miami Beach
Webb, E. Porter	Crestview
Wilensky, M. C.	Chattahoochee
Woolsey, B. F	Jacksonville
Youmans, Iva C	Miami

As will be noted, this registration includes representation from nineteen component societies of the Florida Medical Association. The societies represented are: Alachua, Bay, Broward, Dade, DeSoto-Hardee-Highlands, Duval, Escambia, Hillsboro, Jackson, Lake, Lee, Leon-Gadsden-Liberty-Wakulla-Jefferson, Orange, Palm Beach, Pasco-Hernando-Citrus, Pinellas, Polk, Sarasota and Walton-Okaloosa.

Dr. Gerry R. Holden, president of the Association, made a trip to New York on Saturday, May 28th, returning the following Monday. While in New York, he visited his daughter, Miss Katharine Holden, who is in charge of the Department of Physical Education at the Hillside School, Norwalk, Connecticut, and his son, Gerry R. Holden, Jr., who is a special agent for the Maryland Casualty Co., working out of their New York office.

Dr. J. S. McEwan recently made an airplane trip to Baltimore where he spent a week with his medical friends in and around the Johns Hopkins medical center.

Dr. C. C. Rudolph of St. Petersburg returned recently from Washington, D. C., where for several weeks he had been engaged in post-graduate work.

Dr. Clarence E. Hutchinson, who for many years was a resident of Pensacola, died at Ocean Springs, Mississippi, on April 24th. During his residence in Florida, Dr. Hutchinson was a member of the Escambia County Medical Society and the State Association. He retired in 1928 at which time he moved to Ocean Springs, Mississippi.

At its June meeting, the Duval County Medical Society adopted the following resolutions on the death of Dr. Norman M. Heggie:

"Resolved, That in the death of Dr. Norman M. Heggie the Duval County Medical Society deeply regrets the passing of one of its most worthy and beloved members. That his death was a great loss to the city and community which he served so generously and faithfully.

"From the members of his chosen profession he received many honors. Dr. Heggie was a member of the Board of Governors of the American College of Surgeons and one of the first five men appointed as a member in this state. He was a member of the American Board of Ophthalmologic Examiners, a member of the Board of Ophthalmology, the American Academy of Ophthalmology and Otolaryngology, the Southeastern Surgical Congress, and a former president of the Duval County Medical Society.

"The members of the Duval County Medical Society pay tribute to his skill, his progressiveness and his honesty. Therefore, be it resolved by the members of the Society that in his death we, who have known him and worked with him, grieve for the loss of a friend whose life was a lofty illustration of sterling attributes we may hope to emulate.

"Resolved, That we tender to his family a copy of these resolutions with our sincere sympathy.

"Resolved, That these resolutions be entered upon the records of the minutes of the Duval County Medical Society as a memorial of the departed.

"(Signed) Dr. S. A. Morris, Chairman; "Dr. Harry Peyton."

The Chattahoochee Valley Medical and Surgical Association will meet at Radium Springs, Albany, Georgia, July 12-13, 1932. This will be an unusually interesting meeting. In reality, this is rapidly becoming a tri-state association, as the program this year is about equally divided among the members from Alabama, Florida and Georgia. All of Georgia and Alabama have contributed heretofore and Florida west of the Suwannee River, but this year, the entire state of Florida will be included. There is much to be gained by association with fellow practitioners in adjoining states. Get ready for the Albany meeting. You will find Radium Springs is a good, cool place in which to enjoy this splendid scientific program, as well as to swim, golf, tennis, bridge, dance and rest. This is the first year the entire state of Florida has been invited and the first year one of our members has been selected as president.

Dr. Homer L. Pearson of Miami represented the Dade County Medical Society at the National Milk Commission held in Washington, D. C., during the middle of May.

COMPONENT COUNTY SOCIETIES DADE COUNTY MEDICAL SOCIETY

The annual banquet of the Dade County Medical Society was held Saturday evening, May 21, at seven o'clock in the main dining room of the Pancoast Hotel, Miami Beach, taking the place of the regular monthly meeting of the society.

The reception committee was composed of Dr. and Mrs. C. F. Roche, Dr. and Mrs. Elmo D. French, Dr. and Mrs. Frank Davis and Dr. and Mrs. Robert T. Spicer. All those present participated in community singing during the dinner,

after which the guest speakers were introduced, Judge Halstead L. Ritter and Clayton Sedgewick Cooper, author and president of the Committee of One Hundred.

ORANGE COUNTY MEDICAL SOCIETY

The May meeting of the Orange County Medical Society was held in the Orange General Hospital on the 18th. Drs. W. J. Johnston and F. C. Metzger of Sarasota were guests. Dr. Metzger presented a most interesting paper on Allergins and discussed the curious and often surprising behavior of them.

To place under better control and coordination the many demands upon the physicians of the county and especially those in Orlando for attendance on the ever-increasing number of clinics proposed by various civic organizations, on motion, it was proposed that an Orange County Medical Clinic be established in which all the men should take part by contributing a certain number of hours each week for the care of the *indigent* sick. This proposal met with favor and was very actively discussed and a special committee appointed to formulate plans for its inception.

The special legislative committee reported upon its contacts with the men who are candidates for the legislature in the coming election.

A request was presented by one of the physicians that he might be allowed to take space in the daily papers extolling his ability, equipment and institution. This rather unusual request was referred to the Board of Censors for a complete study and a review of somewhat similar activities in the past.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society celebrated President's Night with a dinner at the Yacht Club on the evening of May 19th.

The President, Dr. O. O. Feaster, introduced the honor guests, Dr. Gerry Holden, State President, and Dr. Stewart Thompson, Business Manager of the Association. Dr. Holden spoke very entertainingly of the early days of the Association and outlined its recent accomplishments and future aims. Dr. Thompson spoke briefly of the business methods that are now being used by the Association and activities of the Bureau of Vital Statistics of the State Board of Health. The members evinced a hearty interest in the remarks of their visitors and gave them a vote of thanks for coming down so far to address them.

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION, Inc.

State Editor

Mrs. S. E. Driskell
1410 Windsor Place
Jacksonville, Florida

OFFICERS

MRS. LEICH F. ROBINSON, President	. Ft. Lauderdale
MRS. EUGENE G. PEEK, President-elect	Ocala
Mrs. Arthur L. Walters, Vice-President	. Miami Beach
MRS. ERNEST W. VAAL, Secretary Treasurer	So. Jacksonville

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Mrs.	W. W. KIRK,	Finance						. Jacksontille
Mas.	J. R. WELLS,	Public R	elat	ion	8			Daytona Beach
MRs.	H. Q. Jones	s, Hygeia						. Ft. Myers
								. Jacksonville

VISIT FROM THE NATIONAL PRESIDENT-ELECT

Mrs. Walter Jackson Freeman of Philadelphia, then president-elect of the American Medical Auxiliary, visited several state conventions en route to the A. M. A. meeting in New Orleans, and it was indeed fortunate for us that there were a few days between South Carolina's annual meeting and that of our own state for it gave us the privilege of having her visit several of our County Auxiliaries.

Mrs. Freeman arrived in Jacksonville on the morning of April 26 and that afternoon the Duval Auxiliary gave a tea in her honor. Mrs. E. W. Veal, county president; Mrs. S. E. Driskell, state president, and Mrs. Freeman received the guests, after which Mrs. Freeman made an inspirational address telling the why and how of auxiliary work. During the social hour Mrs. Edward Jelks and Mrs. L. V. Tyler served at the beautifully appointed tea table.

On the 27th Mrs. Edward Jelks, state editor, was hostess to Mrs. Freeman, Mrs. Driskell, and Mrs. Veal, state secretary-treasurer, at a luncheon at the Jacksonville Woman's Club, at which time Mr. H. H. Hume spoke on, "Conservation of Plant Life", and Mrs. Freeman spoke on, "Conservation of Human Life."

Following the luncheon the party of four motored to St. Augustine to the home of Mrs. J. M. Irwin, state historian, who was hostess at a delightful tea, every local doctor's wife being present except one who was out of town.

A feature of the afternoon was the display of the history and scrap book of the State Auxiliary which has been so beautifully and completely arranged by Mrs. Irwin.

On the 28th Mrs. Freeman, Mrs. Jelks, Mrs. Veal and Mrs. Driskell drove to Ocala to the home of Mrs. Eugene G. Peek, who took them in her car to Indian Lodge at Silver Springs where a lovely luncheon was given jointly by the Alachua and Marion Auxiliaries. There was a splendid representation present from each of these groups. Following the enjoyable luncheon in this picturesque setting the ladies listened to a most interesting address by Mrs. Freeman and then the visitors were treated to a ride in a glass-bottom boat over beautiful Silver Springs.

On the 29th Mrs. Freeman went to Daytona Beach where she was the guest of Mrs. J. Ralston Wells, most immediate past state president, and on the 30th Volusia Auxiliary entertained for her at a luncheon at the Terrace Inn. Daytona Beach. Fifteen members attended the luncheon, which was presided over by the president, Mrs. L. V. L. Brown, of DeLand, and were inspired by the presence and interesting address of the National president-elect.

From Daytona Beach Mrs. Freeman, accompanied by Mrs. Wells, motored to St. Petersburg where they were house guests of Mrs. W. G. Post, Jr., state vice-president, and were extensively entertained by the Pinellas County Auxiliary. They were guests at the Auxiliary's annual meeting on May 2nd where the president, Mrs. Alvin Mills, presided at a luncheon meeting held at the Hotel Suwannee.

Then came the state convention at Sarasota where everyone received great benefit from having Mrs. Freeman present.

The Auxiliary was particularly pleased that Dr. G. H. Edwards, president, very graciously asked Mrs. Freeman to appear before the general convention and make a brief talk.

* * * SARASOTA MEETING

In the last Journal we told of the annual Auxiliary meeting but there was no space to tell something of the delightful entertainment provided by the hostess ladies—Mrs. W. J. Johnston, general chairman.

The very name of Sarasota will always hereafter carry with it thoughts of flowers. There were beautiful flowers everywhere, even in every hotel room. These were a special courtesy from the garden club.

On Monday night, May 2nd, there was a Colonial musicale at the Woman's Club. Tuesday morning a visit was arranged to the Out-of-Door School on Siesta Key and an opportunity given to go through the buildings and grounds and see the children at work and at play. Then came the Executive luncheon at Robert's Pavilion, which was followed by swimming and bridge. At the bridge party each player received a nosegay and high score prizes were awarded.

The Beach Club was lovely for the reception and tea. The tea table presented an attractive picture with its scarlet candlesticks and pale yellow tapers. It was centered with a huge vase of crimson bottle brush. Presiding at the tea table were: Princess Cantacuzene, who is the grand-daughter of President U. S. Grant; Mrs. W. J. Freeman, Mrs. S. E. Driskell, Mrs. Jack Halton, Mrs. L. W. Blake and Mrs. T. M. McDuffee. Music was furnished by Mrs. J. F. Robertson, violinist, accompanied by Mrs. W. J. Johnston, pianist.

The annual banquet and ball Tuesday night at the Mira Mar Auditorium was a gala occasion. The dining and dancing were interspersed with interesting stunts, Dr. Jack Halton acting as toastmaster.

Wednesday noon the ladies attended a luncheon at the Whitfield Country Club, and had the great treat of spending the afternoon in the marvelously beautiful and interesting John and Mabel Ringling Art Museum, which alone would have made our visit to Sarasota worth while.

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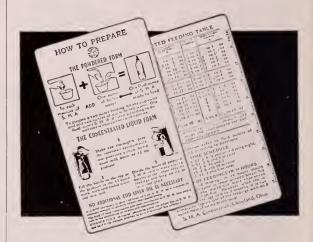


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ERRATA

In the advertisement of the Clear Lake Lodge, appearing in last month's Journal, the address shown and "Orange Clinic" should have been omitted. The correct address of Clear Lake Lodge is 1500 Rio Grand Avenue, P. O. Box 2221, Orlando. The advertisement, in corrected form, appears in this issue on page 557.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACT OF CONGRESS OF AUGUST 24, 1912.

of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., published monthly at Jacksonville, Florida, for April 1, 1932.

STATE OF FLORIDA, & ss. COUNTY OF DUVAL.

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Shaler Richardson, M.D., who, having been duly sworn according to law, deposes and says that he is the editor of the JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in section 411, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of Publisher, Florida Medical Association, Inc. Postoffice address, Box 81, Jacksonville, Fla.

Editor, Shaler Richardson, M.D. Post office address, Box 81, Jacksonville, Fla.

Business Manager, Stewart G. Thompson, D.P.H. Post office address, Box 81, Jacksonville, Fla.

2. That the owner is: (If owned by a corporation, its name and addresses must be stated and also immediately thereunder the names and addresses of stockholders owning or holding one per cent or more of total amount of stock. If not owned by a corporation the names and addresses of the individual owners must

names and addresses of stockholders owning or holding one percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a firm, company, or other unincorporated concern, its name and address, as well as those of each individual member, must be given.) Florida Medical Association, Inc. (A corporation not for profit—no stockholders). G. H. Edwards, M.D., President, 227 No. Eola Drive, Orlando, Floride.

Florida.

A. M. C. Jobson, M.D., 1st Vice-Pres., 226 Lafayette Arcade, Tampa, Florida.

M.D. 2nd Vice-Pres., Pincapple Ave., Sarasota,

Florida.

Shaler Richardson, M.D., Secy-Treas., Box 81, Jacksonville, Florida. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there

amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest, direct or indirect, in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is

(This information is required from daily publications only.)

daily publications only.)

FLORIDA MEDICAL ASSOCIATION, INC., By Shaler Richardson, Editor.

Sworn to and subscribed before me this 1st day of April, 1932. S. G. Thompson,

Notary Public State of Florida at Large. (My commission expires April 9, 1932.) (SEAL)

Form 3526-Ed. 1924.

NOTE.—This statement must be made in duplicate and both copies delivered by the publisher to the postmaster, who shall send one copy to the Third Assistant Postmaster General (Division of Classification), Washington, D. C., and retain the other in the files of the post office. The publisher must publish a copy of this statement in the second issue printed next after its claim.

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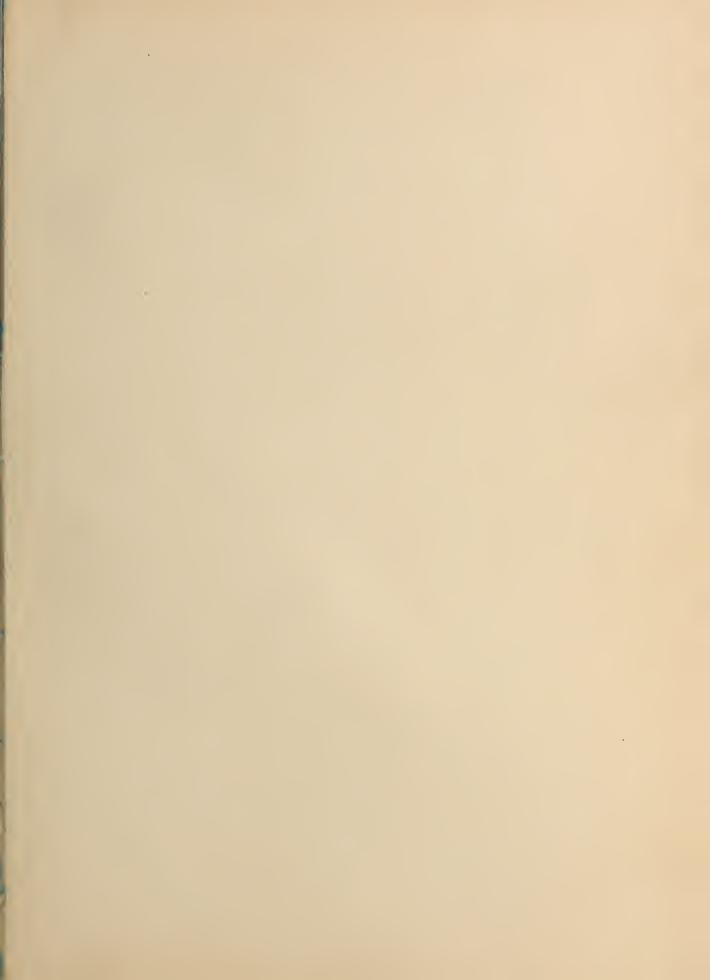
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY	SECRETARY	Date	Time	ETINGS Place	Luncheon?	Dues Paid.
	J. E. Maines, Jr., M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House	Yes.	
Alachua	D. M. Adams, M.D.,	Zhu Tuesuay	12.00 11001	William House	10.	
Вау	Panama City. I. K. Hieks, M.D.,					
Brevard	Melbourne. Anna A. Darrow, M.D.,	3rd Tuesday		Varles		
Broward	Ft. Lauderdale. T. H. Bates, M.D.,	Last Wednesday.	8:00 P.M.	Elks' Hall	No.	
Columbia	Lake City.	1st Monday	7:30 P.M.	Blanche Hotel		
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg.	Occasionally.	
DeSoto-Hardeo- Highlands	L. W. Martin, M.D., Sebring.		8:00 P.M.	Varies	Yes.	
Ouval	F. L. Fort, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel	No.	
Escambla	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building	No.	
Hamilton	J. R. Bruce, M.D., Jasper.					
Hillsboro	J. T. Cowart, M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital	No.	
ackson	T. H. Hudgens, M.D., Sneads.	2nd Tuesday	3:00 P.M.	Marianna	No.	
ake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	
	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital	No.	
con-Gadsden- Liberty- Wakulla- Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	
dadlson	Geo. O. Davis, M.D., Madison.					
Manates	A. Q. English, M.D., Manatee.	1st and 3rd Tuesdays, Oct. to May: 2nd Tues., May to Oct.	7:00 P.M.	Dixie Grande Hotel	Yes.	
Marion	W. B. Jordan, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel	Yes.	
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	
Orange	J. R. Chappell, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	
Palm Beach	V. M. Johnson, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital	No.	
Pasco-Hernando- Citrus	Geo. R. Creekmore, M.D., Brooksville.	2nd Thursday	7:00 P.M.	Varies	Yes.	,
Pinellas	Alvin L. Mills, M.D., St. Petersburg	Every other Thurs.		Assembly Room, 5th floor, P. & L. Bldg.	No.	
Polk	Herman Watson, M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	8:00 P.M. 1:00 P.M.	Lakeland	Yes.	
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday		James Hotel, Palatka	Yes.	
	Reddin Britt, M.D.,		7:00 P.M.			
St. Johns St. Lucie-Okeecho- bee-Indian	St. Augustine. J. D. Parker, M.D.,	3rd Tuesday	8:30 P.M.	Varies	Yes.	
River-Martin	Stuart. J. C. Patterson, M.D.,	3rd Thursday	8:00 P.M.	Varies	Yes.	
Sarasota	Sarasota. J. T. Denton, M.D.,	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	
Seminole	Sanford. W. E. Mitchell, M.D.,	2nd Friday	8:00 P.M.	City Hospital		
Sumter	Coleman.	2nd Tuesday		Varies	No.	
Taylor	Jas. L. Weeks, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel	Yes.	
Volusia	Joseph H. Rutter, M.D., Daytona Beach.	2nd Tuesday	7:30 P.M.	Varies	Yes.	
Walton- Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	
Washington- Holmes				J.		







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